THE NARCOTIC PROBLEM

A Brief Study

STATE OF CALIFORNIA
DEPARTMENT OF JUSTICE
STANLEY MOSK, ATTORNEY GENERAL

Prepared by
BUREAU OF NARCOTIC ENFORCEMENT

STATE OF CALIFORNIA

DEPARTMENT OF JUSTICE

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BUREAU OF NARCOTIC ENFORCEMENT
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T H E N A R C O T I C P R O B L E M

A BRIEF STUDY

(Third Edition)

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F O R E W O R D

This pamphlet was prepared by the Bureau of Narcotic Enforcement in response to the many requests received for information concerning narcotics. It does not purport to be a complete study of the narcotic situation. Rather, it was intended to touch on the high points and answer the questions most frequently asked.

Every effort has been made to check the accuracy of the contents. Where controversial points were encountered, the consensus of the opinions expressed by recognized experts in the field has been used.

It is hoped that this pamphlet will give the reader a greater knowledge and better understanding of the narcotic problem in California as it exists today.

Stanley Mosk

STANLEY MOSK
Attorney General

STATE BUREAU OF NARCOTIC ENFORCEMENT

The State Bureau of Narcotic Enforcement had its beginnings in 1927. At this time it was known as the Division of Narcotic Enforcement, and it was a branch of the California State Board of Pharmacy. At its inception the Division was composed of a chief, ten inspectors and one clerk.

In 1929 the Division became an independent unit, and the chief, appointed by the Governor, was empowered to employ attorneys, chemists, inspectors, clerks, and other employees. Two of the inspectors were required to be licentiates in pharmacy.

The Bureau maintained its independent status as a Division until 1944 when it became a Bureau with the Department of Justice.

Over the years there has been a steady increase in the number of personnel authorized the Bureau, and today the Bureau employs 116 Civil Service personnel, 89 of whom are peace officers.

In addition to the regular Narcotic Agents, these personnel include Narcotic Chemist Agents, Narcotic Pharmacist Agents, and Spanish-speaking Narcotic Specialist Agents.

The Bureau is headquartered in Sacramento and has five operating Field Offices, each under the direction of a Supervising Agent, located in Sacramento, San Francisco, Fresno, Los Angeles, and San Diego.

The Bureau is charged by statute with enforcement of that part of the Division 10 of the Health and Safety Code known as the State Narcotic Act. This means that the enforcement problem of the Bureau is the regulation and control of legitimate supplies of narcotics and the total suppression of illicit use and traffic.

This over-all general mission is broken down into six objectives in the order of priority as follows:

a. Detection and apprehension of major narcotic violators and sources of supply.

b. Enforcement of statutes relating to individuals licensed to prescribe, furnish, administer, possess or dispense narcotics.

c. Cooperating with and training of other enforcement agencies in the suppression of narcotics traffic at all levels.

d. Processing and safekeeping of vehicles impounded in connection with the enforcement of the narcotic laws.

e. Chemical analysis of suspected narcotics.

f. Receipt, security and destruction of all narcotic evidence.

Of the various types of specialized criminal investigation (arson, homicide, robbery, burglary, etc.), perhaps the most difficult to bring to a successful conclusion is the narcotic investigation. Crime involving narcotics, unlike other crimes, normally has no victim. In the case of a robbery, for example, the person who is robbed is the victim and reports to the police the circumstances surrounding the robbery. In the case of a narcotic crime, however, both the seller and the purchaser of narcotics are guilty of a crime, and it is highly unlikely that either will report the commission of this crime to the police. It follows, then, that the Narcotic Agent must not only apprehend the persons who committed a crime but must first discover that the crime was committed, or, the still more difficult task, that it is about to be committed.

A further obstacle thrown into the path of a narcotic investigator are the present laws regarding search and seizure. The mere fact that a narcotic officer is morally certain that a suspect is in possession of narcotics is not sufficient to permit the narcotic officer to search the suspect and use any narcotics found in his possession as evidence to prosecute the suspect. As a result, the narcotic officer must spend long hours of investigative time in an effort to obtain sufficient evidence to sustain a conviction.

Notwithstanding the various handicaps which strew his path, the efficiency of the State Narcotic Agent is attested to by the number of arrests and the narcotic seizures made each year. For example, in 1961, a typical year, State Narcotic Agents conducted 5,476 narcotic investigations. These investigations were culminated by 1,251 arrests and the seizure of over 10,000 ounces of various narcotics. To accomplish this, each Agent worked on the average of 416 hours of non-compensable overtime. Similarly, in 1962 and 1963 State Narcotic Agents worked an even greater number of hours, conducted more investigations, arrested a total of 2,893 individuals, and seized 37,600 ounces of narcotics. This type of selfless dedication and strict attention to duty is an essential ingredient in the successful Narcotic Agent.

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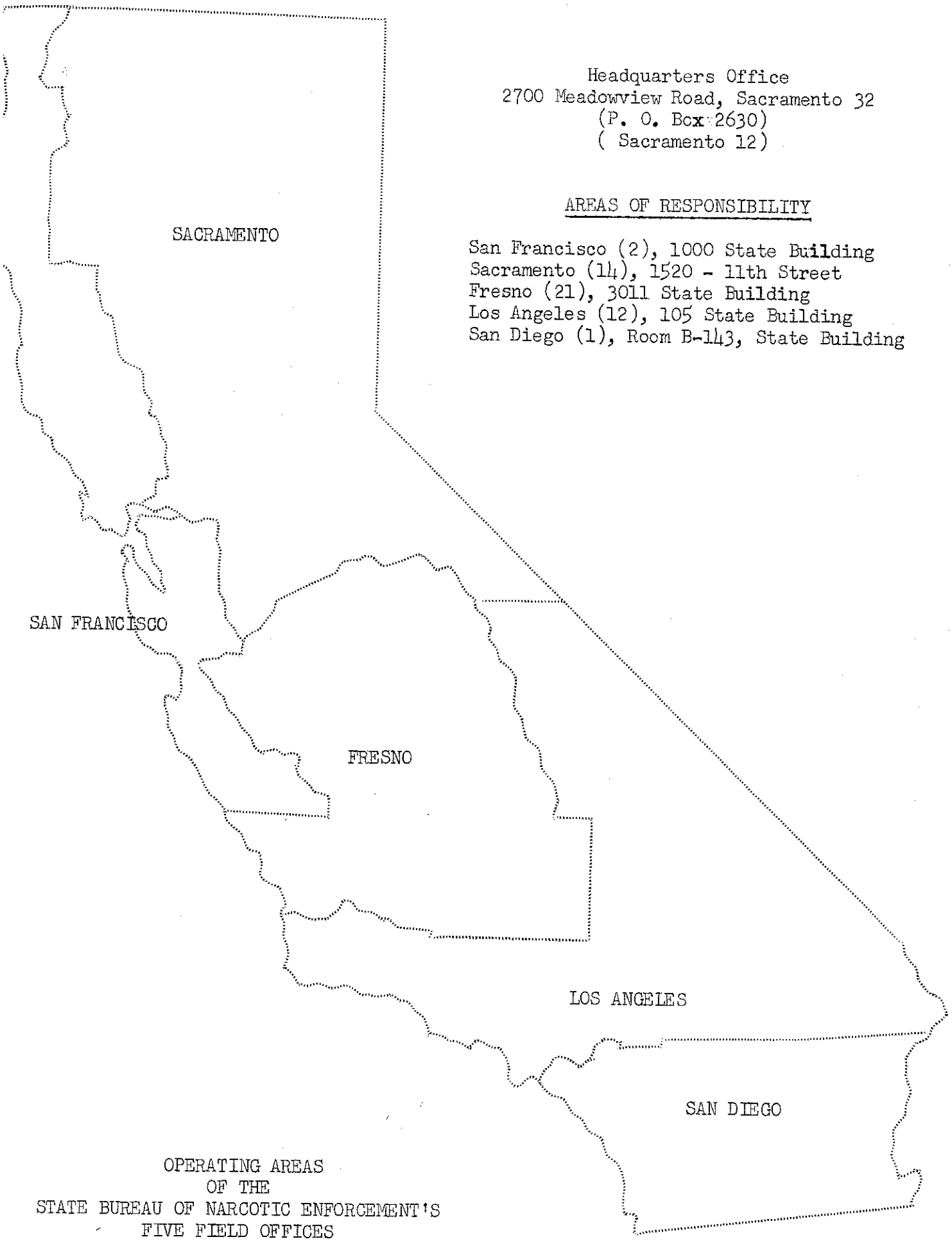


OPERATING AREAS
OF THE
STATE BUREAU OF NARCOTIC ENFORCEMENT'S
FIVE FIELD OFFICES

HISTORICAL BACKGROUND

Some five thousand years before the birth of Christ people of what is now Iraq recorded the earliest known information about narcotics. The great Greek physician Hippocrates, in the 4th Century, B.C., recommended white poppy juices for a variety of illnesses (opium is obtained from the poppy). The Spaniards, while conquering and exploring Latin America, noted that the natives were stimulated by chewing the coca leaf, from which cocaine later derived its name.

But no one seems to have sounded an impressive alarm about the improper handling of the useful narcotic drug until 1729 when Yung Cheng, a Chinese Emperor, issued the first edict prohibiting opium smoking. Apart from the Catholic Church's prohibition of peyote consumption by the American Indians, this appears to be the earliest general official regulatory measure directed against narcotics. The imports of opium into China had developed into a big business as addiction became widespread. The Chinese addicts paid little or no attention to their Emperor's command.

Subsequent Emperors issued many edicts prohibiting the use and importation of opium, but because of the inability of the government to enforce these measures they were generally ignored, and a large fraction of China's annual earnings were siphoned off by the opium importers. In 1839 the Chinese Emperor appointed an energetic administrator, Commissioner Lin, in charge of Canton. Lin demanded the surrender of all opium stored in Western ships and held in warehouses in compliance with Chinese law. To insure compliance, he forcibly detained all Westerners in Canton. As the opium was surrendered the detained Europeans were released.

This new and bold approach was a blow to Western profits as well as prestige, and resulted in a good deal of tension, particularly between the British and the Chinese. Certain drunken sailors, British or American, or both, became involved in a brawl which resulted in the death of a Chinese. The Chinese demanded the surrender of British seamen thought to have been involved and the British refused. This precipitated the struggle known as the "Opium War" (1840 to 1842). Following the war, in which the Chinese were defeated, the importation of opium was resumed and Chinese domestic production mounted until in 1906 the annual Chinese production was estimated at forty-four million pounds of opium, with seven million pounds coming into the country from India.

In America, a trickle of narcotics started coming to our shores even before the founding of the republic. In the latter 1800's the volume began to swell and the problems of addiction began to increase. In 1853 the hypodermic needle was invented by Dr. Alexander Wood of Edinburgh. The injection method of using morphine was thought to be free from addiction as the drugs would not reach the stomach and so create an appetite. For a while patients were encouraged to buy

this new device and apply the morphine on a do-it-yourself basis.

By the time the war between the States ended in 1865 many thousands of soldiers had received numerous injections to relieve their suffering from wounds and sickness. So many of those treated became addicts that morphinism came to be known as the "Army Disease."

With the growth of advertising, which in those days promoted patent medicines containing narcotics, many persons who took such medicine became dependent upon it. Later they often found out about the specific narcotic ingredient and started using that. The passage and enforcement of the Pure Food and Drug Act in 1906 helped to relieve this particular situation.

In 1874 diacetylmorphine, or what we now know as heroin, was developed in England. There was little interest in this drug until about 1890, at which time it was reported as a more effective remedy for illnesses which had been treated with codeine or morphine. In response to the favorable reports and the increasing interest of the medical profession the Bayer Company of Elberfeld, Germany, started production of heroin commercially in 1898. Within four or five years scientists became doubtful of the value of heroin as a cure for morphinism. An increasing number of heroin addiction cases were being reported and they seemed much more difficult to cure than in the case of morphine.

It took the medical profession a long time to fully appreciate the dangers of heroin addiction. The underworld, however, quickly appreciated the new drug. Since it could be taken in snuff it appealed even to those who were repelled by the use of the hypodermic needle. It might be added, however, that those who became addicted to heroin usually were soon converted to the injection method and eventually to the intravenous method, becoming "mainliners."

Because of the increasing number of addicts, the public and Congress became aroused and the Harrison Narcotic Act was passed in 1914.

During World War I a vast number of Americans, including both military and civilians, were drug addicts. Statistics on the subject at that time were not carefully compiled, but there were indications that there were at least 200,000 addicts, probably many more.

Today the Federal Government estimates that there are approximately 60,000 addicts, of whom about 46,000 have been officially reported. It must be noted, however, that these estimates are based on a voluntary reporting system, with a consequent high degree of inaccuracy contained within the figures.

NARCOTIC DRUG-CLASSIFICATIONS

A narcotic is a drug which, in proper doses, relieves pain and induces profound sleep, but which, in poisonous doses, induces stupor, coma, or convulsions. Narcotics tend to be habit-forming and, in many instances, repeated doses lead to addiction. Properly used for medically prescribed purposes, narcotic drugs are a great boon to mankind. It is in misuse, and abuse, that narcotics are transformed from a boon to a bane.

Narcotics may be divided into two main groups--stimulants and depressants. The stimulants tend to excite the nervous system and keep the user awake. Depressants produce drowsiness and sleep. The most dangerous among the stimulant drugs is cocaine. Chief among depressant drugs are opium and its derivatives.

Within the last twenty years or so chemists have produced synthetic narcotics, many of which may be directly substituted for opium derivatives. Most common among these are Demerol and Methadone. These drugs relieve pain and, in some cases, are just as addicting as morphine. The synthetics, in general, may be classified as depressant drugs, and produce much the same physiological reactions as are produced by morphine, Dilaudid, or other preparations derived from the opium poppy.

Let us more carefully examine the more important narcotics.

Opium

The United States Pharmacopeia defines opium as follows: "Opium is the air-dried milk exudation obtained by incising the unripe capsules of Papaver somniferum (Linne) or its variety album De Candolle (Fam. Papaverceae). Its yield is not less than 9.5 per cent of anhydrous morphine."

Opium, as indicated above, is obtained by making incisions in the unripe capsule or seed pod of a poppy. The incisions are made in the late afternoon and the gum is collected the following morning. This gum, in its natural state, is a milky white substance. After the incision is made the gum will seep through the incisions and collect on the outer surface of the pod. Because of its exposure to the air the gum oxidizes, turning to a very dark reddish-brown. The gum is collected by scraping it from the sides of the pods. The opium is then sent to laboratories where it is refined and the alkaloids extracted for medicinal purposes. The poppy plant from which opium is extracted grows mainly in India, China, Turkey, Iran, and Yugoslavia.

Opium is graded by its morphine content, and the United States Pharmacopeia specifies that the gum shall yield no less than 9½ per cent morphine. Any drug containing less than 9½ per cent

morphine is considered unfit for medical use.

Opium that has been cultivated for use in the illicit traffic is sent to laboratories where a solution of glycerine and water is added and the mass boiled down to the consistency of heavy molasses. It is processed by further cooking to evaporate the water, the remaining glycerine keeping the opium pliable. This is known as smoking opium. Prior to Pearl Harbor smoking opium, for the most part, was smuggled into this country from ships arriving from the Orient. Since Pearl Harbor the greater percentage of opium used by the underworld in the United States is supplied by Mexico. Those interested in the cultivation of the opium poppy below the Mexican border have successfully cultivated a plant producing gum with a morphine content of from 2 to 8 per cent.

Opium in the underworld is referred to by various names. For instance--"Mud," "Tar," "Black Stuff," "Hop," "Pen Yan," and "Yen Pocks"--the latter being opium pills rolled for smoking and which may also be taken orally. The containers used for the opium are known as "Toys," "Jars," "Cans," or "Bindles," depending upon the size of the container.

The illicit use of opium is confined almost exclusively to persons of oriental extraction, particularly Chinese. For the most part, opium is used by smoking it in an opium pipe. The drug is rolled into small pills and is brought over the flame of an opium lamp before being placed in the bowl of the pipe. As the pill burns it gives off a sickening sweet odor. The fumes, not smoke, are drawn into the lungs of the smoker through the stem of the pipe. After initially smoking the opium pill there remains in the pipe bowl a residue or ash which, using Chinese terminology, is called "Yen Shee." The "Yen Shee," which is high in morphine content, is scraped from the bowl and the stem and set aside for subsequent use in the event the addict is unable to obtain his regular supply of opium.

In recent years the use of smoking opium has practically disappeared. This disappearance was probably brought about by the difficulties encountered in smoking opium without detection. Considerable paraphernalia and advance preparations are required before the smoking may commence. Once the pipe is lit the opium gives off a distinctive, easily-identified odor which will carry for a considerable distance and greatly increase the chances of detection.

Morphine

Morphine, a principal alkaloid or active constituent of the drug opium, was discovered early in the 19th century. The alkaloid appears in transparent white rhombic prisms or fine needles and as a powder in crystal form. Like most alkaloids, it has a very bitter taste. For medicinal purposes, the average dose of morphine is $\frac{1}{4}$ grain. However, in extreme cases of acute pain, $\frac{1}{2}$ grain may be administered.

The tolerance for this drug builds up very fast. Persons addicted to the use of morphine may use as much as 10 grains or more of the drug three times a day. Subjects addicted to smoking opium often turn to the use of morphine. This primarily is a matter of convenience because the paraphernalia necessary to carry on the opium smoking habit is quite cumbersome. Prior to World War II, particularly on the West Coast, morphine was considered the greatest problem from a drug addiction standpoint. Since World War II heroin has largely supplanted morphine throughout the United States as the drug of choice among addicts.

Heroin

Heroin is the indirect derivative of the drug opium. It is known chemically as Diamorphine Hydrochloride, Diacetylmorphine, or Heroin Hydrochloride. This drug is manufactured by treating morphine with acetyl chloride, washing the product with a diluted alkaline solution and crystallizing it with the aid of alcohol. Heroin is an odorless crystalline powder with a very bitter taste, ranging in color from colorless to a khaki-tan color, depending upon the adulterant used and variations in the chemical processing of the morphine.

In its general physiological action heroin acts much like morphine except that it is a depressant to the spinal cord. It is, however, about twice as powerful in its depressant action upon the respiratory center. For this reason it is inferior to morphine as an analgesic but it is often of much value in cases where there is an idiosyncrasy to morphine. Its most important use in medicine was as a sedative to the respiratory center. The normal medicinal dose of heroin was, on the average, 1/12 grain, as compared with 1/4 grain for morphine. Because tolerance to this drug builds up very rapidly, the dangers of addiction to it are more pronounced than to any of the other opiates. For this reason, the United States Government, in 1924, prohibited the further importation of opium for the purposes of manufacturing heroin, and no authorized manufacture of the drug has taken place since that time. However, small quantities of the drug produced before 1924 remained in the channels of trade and its medicinal use was not prohibited until July, 1956, when a law was approved requiring all stocks of the drug to be surrendered on or before 19 November 1956. As a result, heroin is no longer used in the United States for medicinal purposes, and possession of heroin is unlawful and the drug is subject to confiscation.

The traffic in illicit heroin has been quite extensive throughout the world. At one time heroin was a prevailing drug on the Eastern seaboard, whereas morphine was the prevailing drug on the West Coast. However, today heroin has replaced morphine throughout the country and it is very seldom that morphine is found in the illicit traffic. Law enforcement officers agree that there are no indications of heroin being manufactured in the United States.

It is estimated that 70 per cent of the heroin seized in California was processed from opium extracted from poppies grown in

Mexico. The remaining 30 per cent of the heroin seized in California originated in the Orient or in the Near East. These percentages do not apply to the entire United States as most of the heroin found in other states is imported from the Orient or the Near East rather than from Mexico.

The average drug addict using heroin will dissolve the drug (the amount depending upon the individual's tolerance) in a small amount of water, usually a spoonful. The solution is heated slightly over the flame of a match or candle to bring it approximately to body temperature. A small piece of cotton is usually placed in the bowl of the spoon and the solution is strained through the piece of cotton and drawn into the syringe through the needle. This cotton is kept by the person using the drug and, over a period of weeks, quite a number of these cottons will be accumulated. They are naturally impregnated with heroin, having been well saturated in the solution. At such time as the individual may be unable to procure his regular supply of the drug these cottons are placed in a small amount of water, which dissolves the residue of heroin contained in the cotton, and the resulting solution is then used by the addict.

In the early stages of heroin usage the solution of heroin is injected into the fleshy parts of the arms or legs. Reaction is comparatively slow. In the majority of the cases the subject using heroin will turn from the fleshy parts of the body to the large veins in the crook of the elbows, commonly referred to by the addicts as the "main line." Injection of the solution of heroin into these veins brings about the desired result within a matter of seconds.

Through continued injection into these larger veins the walls of these veins will collapse and finally cease to serve their normal functions. The addict may then seek to inject other veins in the arm, thighs, calves of legs, the feet, the back of the hands, and even between the fingers and toes.

Little precaution is used by the individual addicted to the use of heroin in caring for the needle or the syringe. Aseptics play little, if any, part in the life of an addict. Such lack of precaution is the cause of many infections which heal slowly and leave permanent scars at the point of entry into the veins.

It should be explained here that the hypodermic syringe referred to above is, in most instances, a common eye dropper wrapped on the end with a little tape to hold the hypodermic needle in position. Sometimes a safety pin or razor blade is used to make an incision and the point of the eye dropper is inserted in the incision and the solution is injected into the vein.

The average addict will be found to have in his possession the eye dropper, possibly a razor blade, a spoon, matches, a small amount of cotton, a hypodermic needle, and a heavy rubber band which is used as a tourniquet to distend the veins.

COCAINE

Cocaine is an alkaloid obtained from the leaves of the Erythroxylon Coca and other species of Erythroxylon. Although the Coca plant and its effects were reported by the Spanish explorers in the sixteenth century, little heed was paid to it, and many even doubted the existence of such a plant until the nineteenth century. In 1859 research by the Austrian, Nieman, resulted in the isolation of the alkaloid cocaine. Charles Fauvel in 1876 reported on the anesthetizing effect of cocaine on mucous membrane, and Keller soon afterward recognized cocaine as an anesthetic for operations on the eye.

One of the early hopes for cocaine was that it might be a cure for addiction to morphine. In 1878 an American, Dr. Bentley of Detroit, claimed a successful treatment of several cases of morphine addiction by using cocaine, and his claim was repeated by Dujardin-Beaumetz of France. Their mistake was soon evident. As a result of it, some morphine addicts acquired cocainism in place of the morphine addiction, while others found that cocainism had been added to the original addiction.

The coca plant's natural habitat is the Andes Mountains of South America where it grows in the wild state at an altitude of from 3500 to 6000 feet. More recently, the coca plant has been successfully cultivated in Java, the West Indies, India, and Ceylon, where similar climatic conditions exist. The leaves of the plant contain ½ to 2 per cent of the alkaloid, depending upon their quality.

The coca leaf is used as a stimulant by the Indians of South America. The leaf, separated from the stalk, is chewed into a little ball in the mouth, and then a small quantity of pulverized unslaked lime or a preparation of the ash of the quinoa plant is added for flavoring. When chewed, the leaves first cause a tingling sensation due to stimulation of the taste buds, but the sense of taste is soon lost. These stimulating properties are much greater in a cultivated plant than those growing wild and only the leaves of the cultivated plant are used if they are available.

To obtain cocaine, the leaves are stripped from the branches of the plant and spread out in the sun to dry. Then, by a chemical process, the alkaloid is extracted from the leaf with benzene, and finally it is isolated in a pure form as a salt of hydrochloric acid. The final product, cocaine hydrochloride, is a white crystalline substance looking like sugar which dissolves readily in water. It is easily prepared in the form of tablets for use with a hypodermic needle, or in a powdered form for easy solubility. In this form it is sometimes inhaled by sniffing by an addict. The straight alkaloid, for the most part, is used in ointments and oily solutions. Cocaine has been legitimately used by physicians and dentists by applying the drug solution as a local anesthetic. It has, however, in recent years

been replaced by such synthetics as novocaine, procaine, and other synthetic anesthetics.

The cocaine habit is one of the most injurious of all drug habits. The characteristic symptoms produced by the over-indulgent use of it are changes in the mental and moral qualities, especially characterized by alternate periods of exaltation and depression, loss of appetite and weight, pallor of the skin, insomnia, and general health failure. Hallucinations, such as the sensation of some foreign body under the skin, or insects crawling over the person, result from over-indulgence in the drug. In an effort to relieve the intolerable itching caused by the feeling of insects crawling over the skin, cocaine users have been known to have scratched themselves until they drew blood, or to have attempted to dig the offenders from the skin with a knife blade.

A common hallucination reported by users of cocaine is seeing hordes of small uniformed policemen entering the room under the crack of the door. This hallucination has given rise to the slang expression "the bull-horrors."

The cocaine user's inhibitions are released. The individual is at a loss to measure time and distance. Under the influence of the drug the individual may have maniacal tendencies and be extremely dangerous one moment and the next minute be reduced to a state of quivering fear.

Cocaine, illicitly used, is, for the most part, brought into contact with mucous membrane by sniffing it up the nostril or placing it inside the lower lip where it is picked up by the salivary glands. The drug has been used to a great extent by criminals who felt that they were in need of something to bolster them up before they committed a major crime. Heroin addicts may go on what is termed a "cocaine jag," a diversion to a certain extent or a breakaway from their normal habit. Although cocaine is definitely a habit-forming drug, the habit is no way comparable to that produced by the over-indulgence in any of the opiates and may be broken without any great physical discomfort.

The illicit use of cocaine in California has decreased appreciably in recent times and it no longer presents the serious problem to law enforcement officers that it once did.

MARIHUANA--CANNABIS SATIVA

Marihuana (Cannabis sativa), a drug which contributes heavily to today's narcotic problem, is a product of the hemp plant. This drug, most commonly known in the Western hemisphere as Cannabis Americana and Marihuana, is generally known throughout the world as hemp and in the Asiatic countries as "Hashish," "Hasheesh," "Charas," "Bhang," "Ganjah" or "Gunjah."

Cannabis sativa, or Indian Hemp, is a tall annual reaching to height of from four to twenty feet when mature. The leaves are alternate opposite with each leaf being made up of an odd number of coarse serrated blades with as many as eleven blades to the mature leaf. The hemp plant seems to have originated in Asia Minor, but is now cultivated in many parts of the temperate zone. This plant has considerable commercial value. The stalks and stems are used in the manufacture of rope and hemp cloth, similar to burlap. The fruit of this plant, which is often incorrectly called the seed, after sterilization, has been used extensively as a domestic bird food. The fruit also is valuable in industry as it is a source of a quick drying oil used in paint. It is believed that the hemp plant had its origin in the Central Asian area north of the Himalayas, but it is adaptable to a great variety of climates and is cultivated and grown wild in Asia, Europe, North America and Australia.

The cannabis habit has claimed its victims throughout the oriental countries for over a thousand years. In the last twenty to twenty-five years it has become a problem of great importance in the United States. In this country most individuals habituated to the use of this drug ingest it by smoking. Throughout the Orient the drug is most generally eaten. The leaves and flowering tops of the cannabis plant are covered with a gum or resin. This gum contains the active constituent cannabin, which is a glucoside of the drug. As morphine is to opium and cocaine is to the coca plant, so is cannabin to marihuana.

In the United States when the female plant is mature the leaves and flowering tops are dried in indirect heat, such as under the roof of a barn. The seeds are shaken from the flowering pod. All stalks and stems are removed and the leaves and flowers are crushed or "manicured" by rubbing between the palms of the hands. The resultant substance may be packed in a variety of ways. The most common of these ways are--compressed into bricks, each brick weighing approximately one kilogram (2.2 pounds), packed in an ordinary tobacco can, or loosely stuffed in a paper bag. To use the drug, it is rolled into cigarettes--usually brown, or wheat straw, paper is used--the cigarettes are rolled in double papers, each paper being carefully pasted on the overlapping edge, and the ends tucked tightly in to avoid spillage. The double paper is to protect the cigarette against the possibility of breaking up as they are at times handled by many persons before they reach the consumer. Also, the double paper is necessary

to hold the marihuana flakes which are harsh, dry, and sharp, having a tendency to puncture the paper when handled. The average marihuana cigarette, holding not more than four grains of the drug, may sell at prices ranging up to $1.25 each. In the Near East and in the oriental countries where marihuana is usually eaten, the leaves and flowering tops are gathered, the fruit stalks and stems removed, and the leaves placed on a long napped rug. This rug is rolled back and forth for hours. The gum from the leaves will adhere to the nap of the rug. After the rolling has been completed, the leaves and flowers are thrown away and the gums scraped up from the nap. This gelatinous mass is made into a type of candy and is eaten and chewed by the natives habituated to the use of the drug.

Marihuana releases the inhibitions of the users, as does cocaine. It ordinarily produces a state of intoxication and a feeling of exaltation, stimulation and release. The user may begin giggling or laughing uproariously. His perception of time, space, and distance is distorted so that objects begin to appear larger or smaller than the actual size, seconds seem like hours. He may be driving 80 miles per hour and believe that he is only doing 20. Marihuana may produce greatly varying effects upon different individuals, ranging from mere excessive affability to maniacal frenzy, and on different occasions it may bring about greatly varying stages of intoxication from the same person. There is no physical dependence created by using marihuana but it does produce both tolerance and habituation. It is an addicting drug only in the sense that existing psychological factors in the individual may lead him to depend upon its use. Its greatest dangers are that the intoxication and hallucinations produced may lead to violent conduct, such as attacking a friend thinking that it is necessary for self-defense, and that it may lead to the use of other more addictive drugs.

Marihuana is used to a great extent in combination with alcohol, which produces an uncontrollable intoxication. The subject is very dangerous to handle, knows no fear, and may cause considerable difficulty in being placed under restraint. It is possible that repeated indulgence in the use of marihuana may produce mental deterioration. It has been reported that many of the mental institutions throughout the Near East and Far East attribute the condition of their insane patients to the over-indulgence of the drug hashish or bhang, as marihuana is known in those countries.

In California narcotic laws provide that marihuana may not be cultivated. However, California provides the proper climate and the fertile soil that is required in the growth of this drug. Marihuana requires a considerable amount of water for growth and in California where the rainfall is limited during the growing season, constant irrigation is necessary. Practically all marihuana found by Narcotic Agents comes from Mexico except for limited garden and flower box culture within the state. No very large scale production in California has ever been detected.

The user of marihuana is a dangerous individual and should definitely not be underestimated by police officers. Caution should be used at all times in taking any drug user into custody, but particularly individuals who are known users of either cocaine or marihuana. They may be dangerous, hard to handle, and might resort to any act of violence.

PEYOTE

"11540 Health and Safety Code. Every person who plants, cultivates, harvests, dries, or processes any plant of the genus Lophophora, also known as peyote, or any part thereof shall be punished by imprisonment in the county jail for not more than one year, or in the state prison for not more than 10 years." Possession of peyote is also contrary to law and is covered by Section 11500, Health and Safety Code.

From "A Manual of Pharmacology" (Sixth Edition) by Torald Sollmann, M.D., Professor of Pharmacology in the School of Medicine of Western Reserve University, Cleveland, the following is quoted:

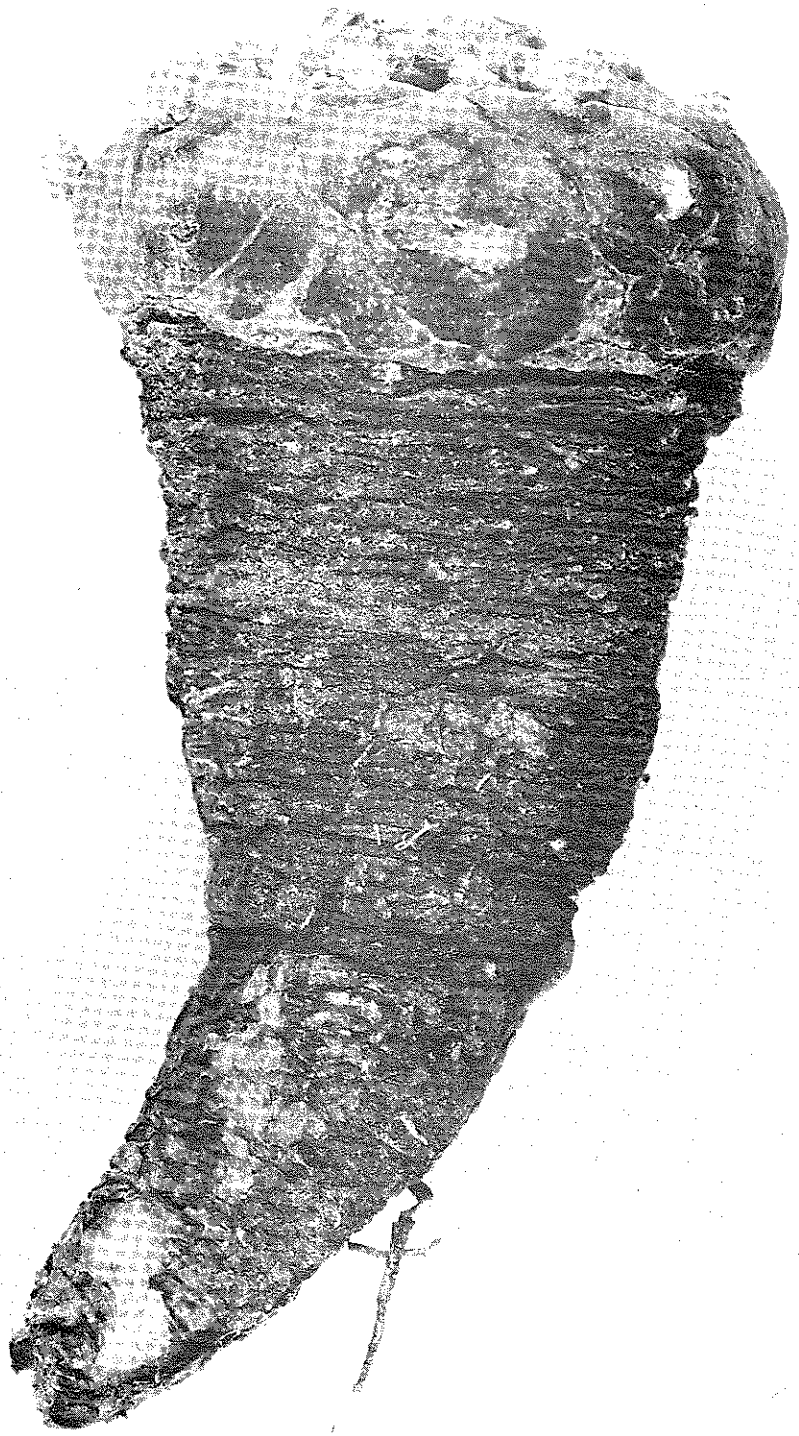
"'Peyote,' misnamed 'mescal buttons,' consists of the tops of a small narcotic cactus, Lophophora Williamsii (formerly Anhalonium Lewinii), which grows in the Rio Grande region of the United States and Mexico. In Mexico 'peyote' refers also to a number of other plants of the most varying kinds, which has resulted in much confusion. It is dried and eaten by the Indian tribes of the Southwest in religious ceremonials, for the sense of well-being which it induces and sometimes to promote trances and hallucinations. Since 1885 the cult has spread extensively among the negroes."

Blair, 1921, claims that the Indians are also using it as a habit-drug, but Safford, 1921, states that its usage is still entirely ceremonial. Schultes, 1937, reports that the Indians consider it as a panacea for practically all illness "as the White uses aspirin."

The cactus contains eight alkaloids. These have all been synthesized. Their actions differ somewhat (Lewin, 1888). Several are sedative. The most important is Mescaline, which produces very peculiar psychologic disorientations, with hallucinations of the special senses, particularly flashes and lines of ever-changing brilliant colors. They appear the same in both eyes and are therefore central (Dixon, 1899). A psychologic study of Mescaline hallucinations has been made by Knauer and Maloney, 1913. Waeber, 1912, failed to find the described visual and auditory effects and double personality, but observed other psychic and physical disturbances. Breeler, 1905, experimented with its actions on mentally deranged patients. E. Guttman and Maclay, 1936, who administered small doses of the synthetic alkaloid orally to psychotic patients, classify the effects as depersonization (confusion of personality), derealization (unreality of environment) and hallucinations similar to schizophrenia. Mescaline and its related compounds produce a number of other effects, including fall of blood pressure, motor paralysis by depression of the central nervous system and death by respiratory failure (G. S. Grace, 1934). Mescaline is not used therapeutically.

A FIELD OF OPIUM POPPIES

GROWING MARIHUANA PLANTS



PEYOTE

Actual Size Including Root

THE TOOLS OF ADDICTION

THE RELATIONSHIP OF NARCOTICS TO CRIME

Narcotic traffic and narcotic addiction go hand-in-hand with crime in general. Recent studies by the State Bureau of Criminal Statistics show that almost 90 per cent of the persons arrested in California for narcotic violations in 1960 had had previous criminal records. The general pattern appears to be that through association with the criminal element individuals become introduced to the use of drugs and, subsequently, become addicted. Drug addicts make up one of the largest criminal groups of today. Each addict generally will introduce at least a half dozen other persons to the use of narcotics. It is for this reason that narcotic addiction is frequently likened to a highly communicable disease and the addict, to avoid spreading the disease, should, like the carrier of the communicable disease, be immediately isolated.

Prostitution and drug addiction are often closely associated. In these cases, it is hard to determine which came first--the prostitution or the addiction. Many prostitutes claim they were addicts first and became prostitutes to support their habit; just as many claim they were prostitutes first and turned to the use of drugs in an effort to make their prostitution more tolerable.

To the individual who is addicted to the use of narcotic drugs there is one thought foremost in his mind--where he may obtain the drug to satisfy his craving and obtain the desired thrill. There are no lengths to which a drug addict will not go in order to obtain his supply of narcotics. He will lie, steal, cheat--all in the hope of obtaining just one small supply of narcotics. Drug addiction is a very expensive habit to maintain. The narcotic addict may spend $20 to $75 for a 24-hour supply of drugs. In some isolated cases, addicts have been known to spend as much as $100 for a 24-hour supply of narcotics. In the use of drugs, little or no restraint is exercised by the addict. The amount of drugs the addict will use over a given period of time is predicated on what he has on hand rather than what his needs are to ward off the onset of withdrawal symptoms. If the user happens to have $100, this will all be spent on heroin, and the heroin used within a comparatively brief period of time, and the user must then obtain the money to purchase a new supply of heroin. The addict, for the most part, in his own right is neither wealthy nor is he earning enough money to support his habit. It follows, then, that the addict must resort to criminal activities of all types to obtain sufficient funds to purchase the drug which he so desperately desires.

Addiction is both a physical problem and a mental problem. Opium and its derivatives react very positively on the human body. Through continued use the drugs of this group alter all natural body functions to such an extent that almost every one of these functions is arrested.

In many cases, the addict takes on a pallor, becomes highly nervous, loses his appetite and sexual desires. The pupil of the eye is contracted. Even when not markedly constricted, it loses the normal fluctuations which are unconsciously noted when observing another person. This lack of mobility gives rise to an expression of the eye which is readily noted by other drug users. Addicts frequently identify other addicted persons by this sign. Every organ and nerve of the body is affected. When the addict finally reaches the point where he is without sufficient drug to satisfy his cravings, nature, in its attempt to restore the natural functions of the body to normal, produces a condition that is accompanied by terrific suffering from the soles of the feet to the top of the head; nerves which were dormant through the period of addiction come to life. Every organ of the body through this readjustment period reacts in a painfully magnified degree. The subject is in a state of complete collapse, accompanied by nausea and vomiting. This period of intense suffering may last for 72 hours. However, it is a matter of weeks, and, in some cases, months before the body resumes its normal functioning.

Socially, the drug addict is a definite outcast except among other addicts. After obtaining legitimate employment it is next to impossible for the addict to devote the time and attention necessary to retain his job. The typical drug addict is untrustworthy, a liar, and a thief, and as he displays these characteristics to his employer he inevitably loses his job. His only recourse then is to give up the habit or resort to crime. Unfortunately, resorting to crime is the easiest of the two possible solutions and the addict commits thefts, burglaries, and other crimes to obtain the money necessary to feed his habit.

Another problem is the diversion of the tax-paid narcotic drugs to illicit channels by thefts from retail drug stores. The forging of prescriptions for narcotic drugs and the obtaining of prescriptions by fraud, deceit, and misrepresentation are also responsible for large quantities of legitimate drugs finding their way into illicit channels. Hundreds of stores have reported burglaries and robberies in the past few years, and hundreds of fictitious and forged prescriptions have been picked up. These methods have thrown thousands of grains of illegal drugs into the hands of persons who realize enormous profits from the illegal sale of these drugs to the addicts.

THE USE OF NARCOTICS BY JUVENILES

After the first World War there was an outbreak of drug addiction among juveniles. The American Medical Association has estimated that in 1924 there were a million addicts in the United States and that a substantial number of them were juveniles. In the early part of the 1920's New York established a narcotic clinic, and out of 3,202 persons treated by it, 1,908 were in the age group of from 15 to 19. In 1925 rumors flooded California that narcotic vendors were operating among school children. An investigation was immediately ordered but not one instance of use of drugs among school children was disclosed. A Los Angeles study during this period indicates that out of 414 narcotics convictions only 5 juveniles were involved.

During the 1930's addiction among the entire population, including juveniles, apparently decreased. From June, 1930, through June, 1932, a total of 9 cases of narcotics users were referred to California Juvenile Courts. In 1938, Santa Barbara was alarmed by rumors that school children were involved in wild marihuana parties. Very little was discovered, but the survey did indicate that the menace of the use of marihuana was increasing on the West Coast.

World War II rather definitely proved that drug addiction had decreased when it was estimated that only 1 out of 10,000 draftees was rejected for addiction as compared to an estimated 1 out of 1,500 draftees rejected for addiction during World War I. In addition, the war greatly reduced the drug traffic as the sources of supply were cut off and the strict wartime customs prevented the little that was available from entering the United States. As anticipated by narcotic law enforcement officers, the problem of addiction multiplied tremendously immediately following World War II. For example, the records of the Federal Hospital at Lexington show that 11 juvenile addicts were admitted for treatment in 1944. 122 were admitted in 1947, and 440 were admitted in 1950. This shows a 2,000 per cent increase in three years, and while most of these juveniles were between 18 and 20 years of age, a substantial portion were under 18.

During this period California showed a similar upward trend in juvenile narcotics addiction. The total number of persons committed to State Adult and Juvenile Correctional Institutions for narcotic violations were as follows:

	Adult	Juvenile (under 18)
1948	105	35
1949	122	34
1950	184	44
1951	393	73

Unfortunately, during the period of 1946 through 1959, there were no comprehensive statistics kept which might give a complete picture of juvenile narcotic offenses. Available statistics were, for the most part, compiled by individual municipalities and do not show, or purport to show, the statewide picture of juvenile narcotic violations. On July 1, 1959, a new unit was created in the Bureau of Criminal Statistics for the express purpose of collecting and evaluating data pertaining to persons arrested for narcotic offenses in the State of California. The first report issued by this unit, which covered a full year's operations, was issued in 1961, and covers the period January 1, 1960, through December 31, 1960. This report was entitled, "Narcotic Arrests and Their Dispositions in California."

The report, "Narcotic Arrests," states, in part, that a total of 1,624 juveniles were reported as having been arrested for 1,220 of these arrests, with the remaining 414 occurring in the rest of the State. Of the total arrestees, 1,316 were boys and 308 were girls. The greatest number of arrests were for offenses relating to possession or sale of marihuana. A total of 677 arrests were made in this category, and an additional 235 were for use of marihuana. This means that 912, or 56.2 per cent, of all juvenile arrests were for marihuana offenses. Heroin type offenses, including the addict-user group, amounted to only 157, or 9.7 per cent of the total. The most common single offenses were possession of marihuana, 620 cases, and the use of marihuana, 235 cases. It is interesting that almost as many arrests of juveniles were made for being under the influence of dangerous drugs, 196 cases, as there were for using or being under the influence of marihuana.

The Special Study Commission on Narcotics, which completed its study in June, 1961, found during the course of their investigation that there was an increasing use of dangerous drugs by juveniles. In a letter transmitting the Special Interim Report on Dangerous Drugs to the Governor, the Commission stated, in part, "As this study progressed, it was brought to our attention that the use of dangerous drugs was closely tied in with the narcotics traffic. Evidence was presented to the Commission that the use of these drugs was replacing marihuana as the first step to the use of heroin. The dangerous drugs referred to include the hypnotics (Seconal, Nembutal, Amytal, Phenobarbital, and the other barbiturates) and the stimulant drugs from the amphetamine group (Dexedrine, Benzedrine, etc.) These drugs are more commonly referred to by the users as 'bennies,' 'goof-balls,' 'red devils,' 'blue heaven,' 'Mickey Finns,' 'knockout drops,' 'yellow-jackets,' and 'green jackets.'

"The most alarming fact brought to our attention is the sharp increase in the use of dangerous drugs by school children because these drugs are so readily available and accessible. In 1959, 10 per cent of the total arrests made by the Juvenile Narcotics Squad of the Los Angeles Police Department involved dangerous drugs. In 1960 this figure increased to 32 per cent of all

such arrests. In the first four months of 1961, 59 per cent of all the arrests made by the Juvenile Narcotics Squad of Los Angeles involved dangerous drugs. Furthermore, the number of arrests of Los Angeles juveniles for dangerous drugs violations have increased 468 per cent since 1954.

"While the majority of those persons who become addicted to heroin have poor school records and a history of criminal behavior prior to using narcotics, information was supplied by educators and law enforcement officials that the use of dangerous drugs has reached up to include school children with average grades with no prior behavior problems."

Subsequent statistical studies revealed that juvenile marihuana arrests declined rapidly in 1961 and to a lesser extent in 1962. Dangerous drug arrests showed a corresponding growth for both years and in 1962 accounted for the majority of all juvenile drug arrests. It is believed juveniles have traded dangerous drug usage for former marihuana usage.

Of course, for the juvenile to become an addict, he must come in contact with the drug. There are a great many ways in which this may occur. The drug may turn up at parties, social gatherings, or where juveniles associate. Gatherings to listen to hot dance band records, sessions at local soda fountains, and similar group activities offer opportunities for pushers to entice the juveniles into trying something new. Once introduced to drugs, it is easy for the user to contact peddlers.

There are a few symptoms which characterize the juvenile drug addict. These ordinarily are not furtive-looking, sallow-complexioned individuals. Many of these youths are well groomed, and dressed, with satisfactory manners and a reasonably good grammar. Of course, withdrawal symptoms will appear in an addict after abstinence from the drug, and the telltale needle marks would identify many heroin users to the experienced eye. This difficulty of recognition makes the detection of youthful users or addicts a serious problem to the law enforcement agencies since the addict may make enough money by selling the drugs to his friends to assure his own supply. Such juveniles will actively recruit from their acquaintances to find new customers. It has been estimated that a juvenile addict, once hooked, will make five more addicts from among his friends. Obviously, such persons must be segregated and cured as promptly as possible to eliminate them as sources of addiction.

TREATMENT OF DRUG ADDICTS

Although it is difficult to define "drug addiction," this term would include all drugs which may possess addiction qualities. The Expert Committee on Drugs Liable to Produce Addiction of the World Health Organization for the United Nations in 1950 established the following widely accepted definition of addiction--"Drug addiction is the periodic or chronic intoxication detrimental to the individual and to society produced by the repeated consumption of a drug (natural or synthetic). Its characteristics include (1) an overpowering desire or need (compulsion to continue taking of the drug and to obtain it by any means), (2) a tendency to increase the dose, (3) a psychic (psychological) and sometimes physical dependence on the effects of the drug."

From this definition it would appear that the indications of addicting properties in any drug are (a) physical tolerance--i.e., after the drug has been used for some time the quantity must be increased in order to bring about the user's concept of the original effect, (b) physical dependence--i.e., if the administration of the particular drug is materially reduced or discontinued the user becomes physically ill (this condition is referred to as withdrawal symptoms or illness), (c) emotional dependence--i.e., the user possesses an emotional and psychological desire for the effects of the drug.

The exact number of narcotic addicts in California is unknown. However, a continuing statistical study by the State Bureau of Criminal Statistics indicates that there are between 10,000 and 20,000 addicts in California. It should be noted at this point that the Federal Government, in 1960, estimated that there were about 7,400 addicts in California. However, the figures compiled by the Federal Government are figures obtained by voluntary contributions from various law enforcement agencies in the state. On the other hand, the figures compiled by the Bureau of Criminal Statistics are taken from actual arrest reports submitted to the Bureau as a requirement of law by the arresting agency. Therefore, considerably more credence can be given to the figures compiled by the state than those compiled by the Federal Bureau of Narcotics.

The confinement, treatment, and rehabilitation of these addicts presents a problem of major proportions. This has been recognized by the State Legislature who, in the 1961 session, passed new laws relative to the treatment of narcotic addicts. These laws are intended to complement existing laws and aid in the rehabilitation process of the narcotics addict.

Under California law a narcotics addict may receive treatment in certain specified State Hospitals under a Civil Court commitment. Such commitment proceedings can be instituted by an affidavit which alleges that a person ought to be committed as a narcotics

Upon the filing of such an affidavit the Court is empowered a warrant to a peace officer directing that such person be ded and taken to court for a hearing. The person sought to tted as a narcotics addict is entitled to present his answer charge and produce witnesses on his behalf. The Judge may tnesses to be summoned and examined before him. The Court oint two Medical Examiners who must hear the testimony of esses, physically examine the alleged narcotics addict, and tify before the Judge as to the result of the examination. ged narcotics addict shall be present at the hearing and is l to be represented by counsel.

There is no method under the present law for a narcotics ho is voluntarily seeking commitment to waive the hearings l under the Welfare and Institutions Code, Sec. 5353, in o receive immediate hospital care. An adult who is committed ldict may be paroled by the Superintendent of the State Hos- the expiration of three months. Such parole can be granted returning the addict to court for a determination if such is in the best interests of the addict or of society. In n, the Superintendent may discharge any person after three hen he is satisfied the addict will not receive actual bene- n further hospital treatment. Such discharge may be granted returning the addict to court to determine if such discharge ne best interest of the addict or of society.

The Welfare and Institutions Code provides that a girl or harged under the Juvenile Court law, or an adult charged with before any court, may have proceedings against him adjourned sentence suspended when it appears to the court that the per- a drug addict so that proceedings may be taken for a civil ent. If the person is found not to be an addict, the court ceed with a criminal trial or impose sentence. If the person itted, he cannot be released in less than three months. hree months the Director of Institutions may certify to the hat the person has been sufficiently treated or give any dequate reason for discharge, after which the court may order ge of the person so committed or is returned to await further of the court.

Although, as previously stated, there is no method under sent law for a narcotics addict who is voluntarily seeking ent to waive the hearing required by law, an addict may vol- y commit himself for treatment without benefit of hearing to te institution approved by the State Board of Medical Exam- At the present time there are about twenty such institutions out the state, the majority of them being located in the n California area. Persons interested in obtaining a listing e institutions may do so by contacting the Bureau of Narcotic ment or the State Board of Medical Examiners.

The first aim of treatment for narcotic addiction is to

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stop the use of the drug with as little danger to the patient as possible. This is entirely a medical problem and is spoken of as detoxication or detoxification. Three methods of detoxication are employed, each having their advocates and critics. One method, spoken of as "cold turkey," is the immediate withdrawal of drug with no further treatment measures. The second is the substitution of other drugs and various supportive measures following withdrawal. The third method employs gradual withdrawal of the drug by the administration of decreasing doses over days until the drug use is entirely discontinued. Most hospitals employ the second and third methods.

Section 11392, Division 10, of the Health and Safety Code (State of California Narcotic Act) reads: "A physician treating an addict for addiction shall not prescribe for or furnish the addict more than any one of the following amounts of narcotics during each fifteen days of such treatment:

(a) 8 grains of opium
(b) 4 grains of morphine
(c) 6 grains of Pantopon
(d) 1 grain of Dilaudid
(e) 400 mgs. of Isonipecaine (Demerol)
(f) 180 mgs. of Amidone."

Section 11393 provides, "After fifteen days of treatment, the physician shall not prescribe for or furnish to the addict more than any one of the following amounts of narcotics during each day of such treatment:

(a) 4 grains of opium
(b) 2 grains of morphine
(c) 3 grains of Pantopon
(d) 1/2 grain of Dilaudid
(e) 200 mgs. of Isonipecaine (Demerol)
(f) 90 mgs. of Amidone."

The law further provides that at the end of thirty days from the first treatment the prescribing or furnishing of narcotics shall be discontinued.

After the addict has been withdrawn from the use of drugs he is kept in the hospital to build him up again physically and mentally. He is at all times under medical supervision, is required to follow certain diets, and proper medication is applied. When the individual leaves the institution, generally in about ninety days, he has gained between thirty and forty pounds on the average.

Unfortunately, only about 25 per cent of addicts released from institutions carry through their probationary period of, on the average, one year and six months, without reverting to the use of drugs. 75 per cent will violate their probation in some way, usually by returning to the use of drugs. Many of the remaining 25 per cent

will revert at a later date after their probation has expired.

Authorities feel that if provisions were made for follow-up supervision and control of addicts released from institutions, the rate of permanent cures would be greatly increased. As an example of success in the treatment of addiction, over 90 per cent of the physician addicts disciplined by the California State Medical Board have been cured of narcotics addiction. This rate of success is said to be due to the constant supervision exercised by the State Medical Board with the threat or fear of permanent loss of physician's license to practice medicine.

The 1961 Legislature, recognizing the need for rehabilitation with long-term control and supervision, passed into law a change to the Penal Code--Commitment and Corrective Treatment of Narcotic Addicts. In essence, this law provides that a defendant convicted of any crime who is addicted to a narcotic or is in imminent danger of becoming addicted, shall be committed to the custody of the Director of Corrections for up to ten years. This law also provides for the involuntary commitment of persons addicted to the use of narcotics, or by reason of repeated use of narcotics is in imminent danger of becoming addicted who are not charged with a crime.

The law also provides for the establishment of an institution to be known as the California Rehabilitation Center. The principal purpose of this Rehabilitation Center is the receiving, segregation, confinement, employment, education, treatment, and rehabilitation of persons under the custody or in danger of becoming so addicted.

The complete text of this law follows:

CHAPTER 11. COMMITMENT AND CORRECTIVE TREATMENT OF NARCOTIC ADDICTS

Article 1. Administration

6399. It is the intent of the Legislature that persons addicted to narcotics, or who by reason of repeated use of narcotics are in imminent danger of becoming addicted, shall be treated for such condition and its underlying causes, and that such treatment shall be carried out for nonpunitive purposes not only for the protection of the addict, or person in imminent danger of addiction, against himself, but also for the prevention of contamination of others and the protection of the public. Persons committed to the program provided for in this chapter who are uncooperative with efforts to treat them or are otherwise unresponsive to treatment nevertheless should be kept in the program for purposes of control. It is the further intent of the Legislature that persons committed to this program who show signs of progress after an initial or subsequent period of treatment and observation be given reasonable opportunities to demonstrate ability to abstain from the use of narcotics under close supervision in outpatient status outside of the Rehabilitation Center provided for in Chapter 12 (commencing with Section 6550) of this title. Determinations of

progress of persons committed to the program should be based upon criteria to be established by the Director of Corrections with the advice of clinically trained and experienced personnel.

The enactment of the preceding provisions of this section shall not be construed to be evidence that the intent of the Legislature was otherwise before such enactment.

6400. The narcotic detention, treatment and rehabilitation facility referred to herein shall be one within the Department of Corrections whose principal purpose shall be the receiving, control, confinement, employment, education, treatment and rehabilitation of persons under the custody of the Department of Corrections or any agency thereof who are or have been addicted to narcotics or who by reason of repeated use of narcotics are in imminent danger of becoming addicted.

6401. Every person committed pursuant to this chapter who escapes or attempts to escape from lawful custody is guilty of a crime punishable by imprisonment in the state prison for not exceeding seven years. This section does not apply to unauthorized absence from a halfway house.

6402. The director may enter into agreements with the Director of Mental Hygiene pursuant to which persons committed to the custody of either for narcotic addiction or imminent narcotic addiction can be transferred to an institution under the jurisdiction of the other.

6403. (a) There is in the Youth and Adult Corrections Agency a Narcotics Rehabilitation Advisory Council hereafter referred to in this section as the "council." The council shall be composed of nine members, each of whom shall be appointed by the Governor for a term of four years and until the appointment and qualification of his successor. Members shall be eligible for reappointment. The chairman of the council shall be designated by the Governor from time to time. The terms of the members first appointed to the council shall expire as follows: three members on January 15, 1965; three members on January 15, 1966; and three members on January 15, 1967. Their successors shall hold office for four years, each term to commence on the expiration date of the term of the predecessor. Vacancies shall be filled by appointment for the unexpired term. Insofar as practicable, persons appointed to the council shall have a broad background in law, sociology, law enforcement, medicine, or education and shall have a deep interest in the treatment and rehabilitation of narcotic addicts.

(b) Each member of the council shall give such time to the duties of his office as is required. The members of the council shall serve without compensation but shall be reimbursed for any actual and necessary expenses incurred in connection with the performance of their duties under this chapter. The council shall hold at least four meetings each calendar year. The times and places of such meetings shall be designated by the chairman. In addition, the chairman shall, on written request of three members of the council, summon a meeting for the time and place specified in the request. The chairman shall give notice of each meeting to the Administrator of the Youth and Adult Corrections Agency, the Attorney General, the Director of Corrections, the Director of the Department of Mental Hygiene, the Director of the State Department of Public Health, the Superintendent of the California Rehabilitation Center, the Chairman of the Adult Authority, the Chairman of the Board of Trustees of the California Institution for Women, and to representatives of statewide and regional professional organizations which appear to him to have a strong interest in the treatment and rehabilitation of narcotic addicts.

(c) The council shall:

(1) Advise the Governor, the Administrator of the Youth and Adult Corrections Agency, the Director of Corrections, the Narcotic Addict Evaluation Authority, and the Superintendent of the California Rehabilitation Center with respect to the receiving, confinement, control, employment, education, treatment, release policies and procedures, outpatient care and supervision, and rehabilitation of persons who are or have been addicted to narcotics or who by reason of repeated use of narcotics are in imminent danger of becoming addicted;

(2) Study the operation of the California Rehabilitation Center and all research programs conducted in connection therewith, and assist in the planning, evaluating and interpretation of, the detention and treatment program as well as the policies and procedures employed in the supervision and management of persons committed to the program who are in either outpatient status or inpatient status;

(3) Submit at least one report annually to the Governor and the Legislature. Such report or reports will be transmitted through the office of the Administrator of the Youth and Adult Corrections Agency.

(d) The council shall not exercise any administrative functions or responsibilities in connection with the operation of the California Rehabilitation Center and related programs. Its functions and duties are limited to acting in an advisory capacity.

(e) Expenses of the council and its members shall be paid from the appropriation for the support of the California Rehabilitation Center.

6405. The Director of the Department of Corrections shall engage in a program of research in the detention, treatment and rehabilitation of narcotic addicts.

6406. No commitment under Article 2 or 3 of this chapter shall be ordered until such time as the Director of Corrections designates a place or places for the reception of persons committed thereunder and unless space is available therein.

6407. "Narcotic addict" as used in this chapter refers to any person, whether adult or minor, who is addicted to the unlawful use of any narcotic as defined in Division 10 of the Health and Safety Code, except marihuana.

6408. When a court commits a person to the custody of the Director of Corrections pursuant to this chapter, the court shall immediately after making the order of commitment, mail to the Department of Corrections, at the facilities to which the person committed is delivered, a copy of such reports as the probation officer may have made relative to such person.

Article 2. Involuntary Commitment of Persons Charged With a Crime

6450. Upon conviction of a defendant of any crime in a municipal or justice court, if it appears to the judge that the defendant may be addicted or by reason of repeated use of narcotics may be in imminent danger of becoming addicted to narcotics, such judge shall adjourn the proceedings or suspend the imposition of the sentence and certify the defendant to the superior court.

The superior court shall then conduct proceedings to ascertain if such defendant is addicted to narcotics or is in imminent danger of

becoming addicted thereto. Proceedings shall be conducted in substantial compliance with Sections 5353, 5053, 5054, and 5055 of the Welfare and Institutions Code.

If, after a hearing and examination, the judge shall find that the defendant charged is a narcotic addict, or by reason of repeated use of narcotics is in imminent danger of becoming addicted thereto, and is not ineligible for the program under the application of Section 6452 hereof, he shall make an order committing such defendant to the custody of the Director of Corrections for confinement in the facility until such time as he is discharged pursuant to Article 5 of this chapter, except as this chapter permits earlier discharge. In any case to which Section 6452 applies, the judge may request the district attorney to investigate the facts relevant to the advisability of commitment pursuant to this section. In unusual cases, where in the interest of justice would best be served, the judge may, with the concurrence of the district attorney and defendant, order commitment notwithstanding Section 6452. If, upon the hearing, the judge shall find that the defendant is not a narcotic addict and is not in imminent danger of becoming addicted to narcotics, he shall so certify and return the defendant to the municipal or justice court which certified such defendant to the superior court for such further proceedings as the judge of such municipal or justice court deems warranted.

If a person committed pursuant to this section, after conviction of a misdemeanor, is dissatisfied with the order of the court, he may demand a hearing by a judge or jury in substantial compliance with the provisions of Section 5125 of the Welfare and Institutions Code.

6451. Upon conviction of a defendant for any crime in any superior court, if it appears to the judge that the defendant may be addicted or by reason of repeated use of narcotics may be in imminent danger of becoming addicted to narcotics he shall adjourn the proceedings or suspend the imposition of the sentence and conduct proceedings to ascertain if such person is addicted to narcotics or in imminent danger thereof unless in the opinion of the judge the defendant's record and probation report indicate such a pattern of criminality that he does not constitute a fit subject for commitment under this section. If a petition is ordered filed, proceedings shall be conducted in substantial compliance with Sections 5353, 5053, 5054, and 5055 of the Welfare and Institutions Code.

If, after a hearing and examination, the judge shall find that the person charged is a narcotic addict, or by reason of repeated use of narcotics is in imminent danger of becoming addicted to narcotics, he shall make an order committing such person to the custody of the Director of Corrections for confinement in the facility until such time as he is discharged pursuant to Article 5 of this chapter, except as this chapter permits earlier discharge. In any case to which Section 6452 applies, the judge may request the district attorney to investigate the facts relevent to the advisability of commitment pursuant to this section. In unusual cases, wherein the interest of justice would best be served, the judge shall find that the defendant is not a narcotic addict and is not in imminent danger of becoming addicted to narcotics, he shall so certify and return the defendant to the department of the superior court which directed the filing of the petition for such further proceedings on the criminal charges as the judge of such department deems warranted.

If a person committed pursuant to this section, after conviction of a felony, is dissatisfied with the order of the court, he may demand a hearing by a judge or jury in substantial compliance with the provisions of Section 5125 of the Welfare and Institutions Code.

6452. Section 6450 and 6451 shall not apply to persons convicted of, or who have been previously convicted of murder, assault with intent to commit murder, attempt to commit murder, kidnaping, robbery, burglary in the first degree, mayhem, a violation of Section 245 or a violation of any provision of Chapter 1 (Commencing with Section 261) of Title 9 of Part 1 of the Penal Code (but excepting subdivision 1 of Section 261) any felonies involving bodily harm or attempt to inflict bodily harm or any offense set forth in Article 1 (commencing with Section 11500) or 2 (commencing with Section 11530) of Chapter 5 of Division 10 of the Health and Safety Code, or in Article 4 (commencing with Section 11710) of Chapter 7 of such Division 10 for which the minimum term prescribed by law is more than five years in state prison.

6453. If at any time after 60 days following receipt of a person at the facility, the Director of Corrections concludes that the person, because of excessive criminality or for other relevant reason, is not a fit subject for confinement or treatment in such narcotic detention, treatment and rehabilitation facility, he shall return the person to the court in which the case originated for such further proceedings on the criminal charges as that court may deem warranted.

6454. A person committed to the custody of the Director of Corrections pursuant to this article is not required to register pursuant to Article 6 (commencing with Section 11850) of Chapter 7, Division 10 of the Health and Safety Code.

Article 3. Involuntary Commitment of Persons Not Charged With a Crime

6500. Anyone who believes that a person is addicted to the use of narcotics or by reason of the repeated use of narcotics is in imminent danger of becoming addicted to their use or any person who believes himself to be addicted or about to become addicted may report such belief to the district attorney who may petition the superior court for a commitment of such person to the Director of Corrections for confinement in the narcotic detention, treatment and rehabilitation facility.

6501. Every person who knowingly contrives to have any person adjudged a narcotic addict under this article, unlawfully or improperly, is guilty of a misdemeanor.

6502. Upon the filing of a proper petition pursuant to Section 6500, the court shall order the person sought to be committed to be examined by a physician or physicians, by order similar in form to the order for examination prescribed by Section 5050.1 of the Welfare and Institutions Code. The court may also order that the person be confined pending hearing in a county hospital or other suitable institution if the petition is accompanied by the affidavit of a physician alleging that he has examined such person within three days prior to the filing of the petition and has concluded that, unless confined, such person is likely to injure himself or others or become a menace to the public.

6503. At least one day before the time of the examination as fixed by the court order, a copy of the petition and order for examination shall be personally delivered to the person.

6504. The report of the examination by the physician shall be delivered to the court, and if the report is to the effect that the person is not addicted nor in imminent danger of addiction, it shall order the petition dismissed. If the report is to the effect that the person is addicted or in imminent danger of addiction, the court shall set a time and place of hearing and cause notice thereof to be served on the person.

6505. The court may issue subpoenas for attendance of witnesses at the hearing and the person sought to be committed shall have the right to have subpoenas issued for such purpose. At the hearing the person shall have the right to be represented by counsel, to present witnesses on his behalf, and to cross-examine witnesses. If he is unable financially to employ counsel, the court shall, if requested, appoint counsel for him.

6506. At the hearing the court shall determine whether the person is addicted to the use of narcotics or in imminent danger of addiction. If that issue is determined in the negative, the petition shall be denied. If the issue is determined in the affirmative, the court shall order the person committed to the custody of the Director of Corrections until such time as he is discharged in accordance with Article 5 of this chapter, except as provided in Section 6509.

6507. Hearing may be waived by consent of the person sought to be committed, expressed in open court.

6508. If the person so committed or any friend in his behalf is dissatisfied with the order of the court, he may demand a hearing by judge or jury in substantial compliance with the provisions of Section 5125 of the Welfare and Institutions Code.

6509. If at any time after 60 days following receipt at the facility of a person committed pursuant to this article, the Director of Corrections concludes that such person is not, because of excessive criminality or for other relevant reason, a fit subject for confinement or treatment in a facility of the Department of Corrections, he may order such person discharged.

6510. A person committed to the custody of the Director of Corrections pursuant to this article is not required to register pursuant to Article 6 (commencing with Section 11850) of Chapter 7, Division 10 of the Health and Safety Code.

Article 4. Release in Outpatient Status

6515. (a) There is in the Youth and Adult Corrections Agency a Narcotic Addict Evaluation Authority, hereafter referred to in this article as the "authority." The authority shall be composed of three members, each of whom shall be appointed by the Governor, for a term of four years and until the appointment and qualification of his successor. Members shall be eligible for reappointment. The chairman of the authority shall be designated by the Governor from time to time. The terms of the members first appointed to the authority shall expire as follows: one on January 15, 1965; one on January 15, 1966; and one on January 15, 1967. Their successors shall hold office for terms of the predecessor. The governor shall fill every vacancy for the balance of the unexpired term. Insofar as practicable, persons appointed to the authority shall have a broad background in law, sociology, law enforcement, medicine, or education, and shall have a deep interest in the rehabilitation of narcotic addicts.

(b) Each member of the authority shall devote such time to the duties of his office as required for performance of his duties and shall be paid a per diem of fifty dollars ($50) for each day's attendance at a meeting of the authority, for not to exceed 120 days in any year. In addition, each member shall be allowed actual expenses incurred in the discharge of his duties, including travel expenses.

(c) The authority shall maintain its headquarters at the California Rehabilitation Center and shall be provided with necessary office space, equipment and services from funds appropriated to the California Rehabilitation Center.

(d) The authority shall meet at the center or its branches at such times as may be necessary for a full and complete study of the cases of all patients who are certified by the Director of Corrections to the authority as having recovered from addiction or imminent danger of addiction to such an extent that release in an outpatient status is warranted. Other times and places of meetings may also be fixed by the authority. Two members of the authority shall constitute a quorum for the transaction of business. No action shall be valid unless concurred in by two members of the authority.

6516. After an initial period of observation and treatment of six months, and subject to the rules and policies established by the Director of Corrections, whenever a person committed under Article 2 or Article 3 of this chapter has recovered from his addiction or imminent danger of addiction to such an extent that, in the opinion of the Director of Corrections, release in an outpatient status is warranted, the director shall certify such fact to the authority. If the director h not so certified within the preceding 12 months, in the anniversary month of the commitment of any person committed under this chapter his case shall automatically be referred to the authority for consideration of the advisability of release in outpatient status. Upon any such certification by the director or such automatic certification, the authority may release such person in an outpatient status subject to all rules and regulations adopted by the authority, and subject to all conditions imposed by the authority, whether of general applicability or restricted to the particular person released in outpatient status, and subject to being retaken and returned to inpatient status as prescribed in such rules, regulations, or conditions. The supervision of such persons while in an outpatient status shall be administered by the Department of Corrections. Except as may be provided in the conditions adopted for persons in outpatient status or for any such person in particular, such persons are not subject to the provisions of Penal Code Section 2600.

A single member of the authority may by written or oral order suspend the release in outpatient status of such a person and cause him to be retaken, until the next meeting of the authority.

6517. The rules for persons in outpatient status shall include but not be limited to close supervision of the person after release from the facility, periodic and surprise testing for narcotic use, counseling and return to inpatient status at the California Rehabilitation Center or its branches at the discretion of the authority, if from the reports of agents of the Department of Corrections or other information including reports of law enforcement officers as to the conduct of the person, the authority concludes that it is for the best interests of the person and society that this be done.

6518. The Director of Corrections is authorized to establish one or more halfway houses in large metropolitan areas as pilot projects in order to determine the effectiveness of such control on the addict's rehabilitation, particularly upon his release from the narcotic detention and treatment facility. Rules and regulations governing the operation of such halfway houses shall be established by the Director of Corrections and shall provide for control of the earnings of persons assigned to such halfway houses during their residence there, from which shall be deducted such charges for maintenance as the Director of Corrections may prescribe.

Article 5. Discharge of Narcotic Addicts

6520. If at any time the Director of Corrections is of the opinion that a person committed pursuant to Article 3 of this chapter while in outpatient status has abstained from the use of narcotics for at least three consecutive years and has otherwise complied with the conditions of his release, he shall recommend to the Narcotic Addict Evaluation Authority that such person be discharged from the program. If the authority concurs in the opinion of the director, it shall discharge such person from the program.

If at any time the director is of the opinion that a person committed pursuant to Article 2 of this chapter while in outpatient status has abstained from the use of narcotics for at least three consecutive years and has otherwise complied with the conditions of his release, he shall so advise the Narcotic Addict Evaluation Authority, and if the authority concurs in the opinion of the director it may file with the superior court of the county in which the person was committed a certificate alleging such facts and recommending to the court the discharge of the person from the program. The authority shall serve a copy of such certificate upon the district attorney of the county. Upon the filing of such certificate, the court shall discharge the person from the program and may dismiss the criminal charges of which such person was convicted. Where such person was certified to the superior court from a municipal or justice court, the person shall be returned to such court which may dismiss the original charges. In any case where the criminal charges are not dismissed and the person is sentenced thereon, time served while under commitment pursuant to Article 2 of this chapter shall be credited on such sentence. Such dismissal shall have the same force and effect as a dismissal under Section 1203.4 of the Penal Code, except the conviction is a prior conviction for purposes of Division 10 of the Health and Safety Code.

6521. If a person committed pursuant to this chapter has not been discharged from the program prior to expiration of seven years, the Director of Corrections shall, on the expiration of such period, return him to the court from which he was committed, which court shall discharge him from the program and order him returned to the court in which criminal proceedings were adjourned, or the imposition of sentence suspended, prior to his commitment or certification to the superior court; or, if he was committed pursuant to Article 3, shall discharge him. If, however, it appears to the director that such person gives promise that, if his time on the program were extended, he could complete three consecutive years of abstinence from narcotics, the director shall return him to the court from which he was committed, with the recommendation that an extension not to exceed three years

be ordered. The court may order such extension. If it declines to do so, it shall, if the person was committed pursuant to Article 3, discharge him, or if he was committed pursuant to Article 2, return the person to the court in which criminal proceedings were adjourned, or the imposition of sentence suspended, prior to his commitment or certification to the superior court.

If an extension of the commitment is ordered pursuant to the preceeding provisions of this section, the person must be returned to the court and discharged from the program on or before the expiration of 10 years from the date of the original commitment.

Any other provision of this chapter notwithstanding, in any case in which a person was committed pursuant to Article 3 as a result of such person's having requested the district attorney to file a petition for his commitment, such person must be discharged no later than two years and six months after his commitment.

No person committed pursuant to this chapter before the effective date of the 1963 amendments thereto shall be subject to the program for any longer period than the term of his commitment under the law as it read at the time he was committed.

Nothing in this chapter shall preclude a person who has been discharged from the program from being recommitted under the program, irrespective of the periods of time of any previous commitments.

CHAPTER 12. CALIFORNIA REHABILITATION CENTER

6550. There is hereby established an institution, and branches thereof, under the jurisdiction of the Department of Corrections, to be known as the California Rehabilitation Center. Branches may be established in existing institutions of the Department of Corrections or of the Department of the Youth Authority, and in halfway houses, as described in Section 6518. The branches in the Department of the Youth Authority shall be established on order of the Administrator of the Youth and Adult Corrections Agency and shall be subject to the administrative direction of the Director of the Youth Authority.

6551. The principal purpose of the California Rehabilitation Center shall be the receiving, control, confinement, employment, education, treatment and rehabilitation of persons under the custody of the Department of Corrections or any agency thereof who are addicted to the use of narcotics or are in imminent danger of becoming so addicted.

Sec. 17. Nothing in this act shall be deemed to impair the legality or effectiveness of any order made or other action taken that was lawful when taken.

6552. The Director of Corrections shall acquire, or construct, and equip, in accordance with law, suitable buildings, structures and facilities for the California Rehabilitation Center.

6553. The Director of Corrections shall make rules and regulations for the government of the California Rehabilitation Center and the management of its affairs.

6554. A superintendent shall be appointed for the California Rehabilitation Center pursuant to Section 6050, and the Director of Corrections shall appoint, subject to civil service, such other officers and employees as may be necessary.

6555. The supervision, management and control of the California Rehabilitation Center and the responsibility for the care, custody, training, discipline, employment and treatment of the persons confined

therein are vested in the Director of Corrections. The provisions of Part 3 of this code apply to said institution as a prison under the jurisdiction of the Department of Corrections and to the persons confined therein insofar as such provisions may be applicable.

NARCOTIC CLINICS

In their final report to the Governor, the Special Study Commission on Narcotics (1961) stated:

Many of those who seek a panacea solution to the narcotics problem find their answer in proposals to furnish narcotics to addicts at cost in state-operated clinics or dispensaries. The advocates of such an approach argue that the addict is incurable. They state that the addict must have narcotics to stave off unbearable withdrawal symptoms. It is argued that the peddler preys on the misery of these unfortunates by making huge profits by charging exhorbitant prices for illegal narcotics. Give narcotics away and you will take the profit out of the narcotics traffic, is the common argument presented by the supporters of this view.

The Commission believes that such proposals are unsound and based on many erroneous assumptions.

There is no proof that addicts are incurable. Up to the present time, the only attempts at treatment for narcotics addiction have all suffered from the same defect--a lack of mandatory follow-up supervision and control in the community with outpatient treatment and adequate tests to detect relapse to the use of narcotics.

The Commission was advised by the Department of Public Health that an addict not suffering from a serious disability can be withdrawn from the use of narcotics by substituting another narcotic which has minor withdrawal symptoms. This being the case, a serious ethical question would be raised if a doctor were to administer narcotics to an addict to satisfy his hedonistic cravings, rather than for any legitimate medical purpose.

Because of the great interest of many persons in California in the proposals to furnish narcotics to addicts and because of the lack of information as to the merits of such a plan, the Commission has prepared the following analysis of the arguments for and against the so-called "clinic" system. As pointed out above, the Commission believes that the arguments against any such program are compelling and should be followed.

THE "CLINIC" PROPOSALS

A proposed solution to the narcotic problem which continually recurs in various forms is the proposition that narcotics be legally dispensed to addicts. There are two basic variations in the proposals for legally furnishing narcotics. One, the "ambulatory" treatment of addicts would grant physicians latitude to freely prescribe narcotics to addicts; the other, "the narcotic clinics" calls for the creation of special facilities for the administering of narcotics to addicts. The underlying reasoning for both approaches are essentially the same. This report will not distinguish between variants of the basic theme.

The main arguments presented for legally dispensing narcotics can be reduced to the following:

The root of the narcotic problem is economic gain from illegal traffic; hence, it is argued, if narcotics are dispensed legally at low cost, the economic motive is removed and the problem is eliminated.

"The Academy believes that the most effective way to eradicate drug addiction is to take the profit out of the illicit drug traffic. The causes of addiction are cited as: maladjustment, under-privilege, broken home, poverty. Such conditions may well be contributory factors, but they are not, of themselves, the prime cause. Rather, profit looms large as the principal factor."
(Report on Drug Addiction by New York Academy of Medicine; August, 1955, Vol. 31, No. 8-592-707.)

Furnishing narcotics to addicts would facilitate treatment of addicts.

"Addicts resistant to undertaking therapy and continuously refractory to therapy, despite all efforts, should be 'supplied' legally and cheaply with the minimum amount of their drug needs, and efforts to pursuade them to undergo rehabilitation should be continued."
(Report on Drug Addiction by the New York Academy of Medicine: op. cit.)

"The fact that the addict will be placed in contact with a physician will be a major victory in many cases and will go a long way toward eventual rehabilitation."
(Belson, J., in NARCOTICS, USA, edited by Paul B. Weston, Greenberg--Publisher, 1952.)

Dispensing of drugs to addicts is humane and economical since drug addiction is incurable.

"Why not accept the fact that addiction is incurable and then go on to deal with the problem . . . much of this enormous cost (of addiction by trials, imprisonment, etc.) borne by the taxpayer could be abolished if drugs were available to addicts at the legitimate price."
(Dr. J. Ross MacLean, Vancouver, Testimony before Canadian Parliament, Special Commission on Traffic in Narcotic Drugs--Proceedings, March-June, 1955.)

Furnishing of drugs to addicts would enable some addicts to resume their place in society as socially useful citizens.

"The one point of view that has never been officially accepted in the United States is that some addicts can be, and remain useful and law-abiding citizens if they can be provided with their minimum requirements. There is much evidence, as a matter of fact, that many chronically addicted persons are able to carry on their occupations and meet their responsibilities if continuously allowed a small amount of narcotic drug at a price they can afford."
(Howe, H. S.: A physician's blueprint for the management and prevention of narcotic addiction, New York State J. Med., February 1, 1955, p. 341-350.)

5. Dispensing narcotics would reduce its attractiveness to youth.
"If drugs were legal they would lose their glamor and adolescents would not be attracted to them as they are now. Some addicts claim too, that having learned to like narcotics, they resent the legal prohibition and are all the more determined to get them."
(Stephenson, G. H.: Arguments for and against the legal sale of narcotics, THE BULLETIN, Vancouver Medical Association, Vol. XXXI, January 1955, p. 177-186.)

6. Furnishing narcotics to addicts would reduce crime caused by the addict's need to maintain his habit.
"It should be remembered that every addict will get his drug. Under the present laws to do that he must 'push, rob, steal, burglarize or commit forgery'. For, he is desperate when he is without his drugs."
(New York Academy of Medicine: op. cit.)

OPPOSITION TO FURNISHING NARCOTICS TO ADDICTS

The great bulk of expert opinion is unalterably opposed to furnishing narcotics to addicts. The arguments advanced by those opposed to such proposals are as follows:

1. Dispensing narcotics to addicts was tried and proved to be a failure.
"The clinics were operated for varying periods and in one city as long as 4 years. The most comprehensive series of facts, having real scientific value, that had been compiled anywhere in the world, was embraced in the published statistics gathered from analytical study of the nearly 8,000 cases of addiction registered and cared for in narcotic clinics during about 10 months by the Department of Health of the City of New York. These cases were subjected to most careful observation and study by specialists qualified to make scientific analysis and arrive at sound conclusions. They reported, 'we have given the clinic a careful and thorough as well as a lengthy trial and we honestly believe it is unwise to maintain it any longer'."
(Anslinger, H. A., and Tompkins: Narcotic Clinics in the United States in "The Traffic in Narcotics.")

2. Furnishing narcotics to addicts will create new addicts.
" . . . prior to the passage of the Harrison Narcotic Act in 1914, when there was no illicit market and narcotics could be bought for pennies over the counter, the rate of drug addiction was five to eight times the current rate. Thus, if we removed all legal restraints and thereby managed to eliminate the illicit trade in narcotics, there is every reason to believe that the population of drug addicts would be increased at least fivefold."
(Ausubel, D. P., Controversial Issues in the Management of

Drug Addiction: Legalization, Ambulatory Treatment and the British System--a paper read at American Psychological Association, September 4, 1959.)

". . . it seems unlikely that furnishing drugs to addicts legally will stop the formation of new addicts. It might very well enhance the spread of addiction, since the same social factors which presently are associated with addiction will continue to operate despite its source of narcotics." (Council for Mental Health, American Medical Association, "J. of American Medical Association," Vol. 165, November 30, December 7, December 14, 1957.)

6.

. Administering narcotics to addicts would undermine treatment of addiction.

"To protect patients from themselves and from their well-meaning but misguided families, it is the writer's firm conviction that laws pertaining to mental health should be strengthened. Hospitalization and complete treatment, consisting of withdrawal, rehabilitation and re-education should be made compulsory for all habitual users of drugs." (Yost, O. R.: "The Bane of Drug Addiction," MacMillen Co., 1954.)

7.

"Withdrawal of drugs from narcotic addicts on an outpatient or office basis should not be undertaken; it almost surely will fail. . . . In the treatment of addiction, short hospitalization for withdrawal without a prolonged period of institutional rehabilitation is as futile as simple detoxification for chronic alcoholism". (Vogel, V. H., Isbell, H. and Chapman, K. W., Present Status of Narcotic Addiction, "J. of American Medical Association," Dec. 4, 1948, Vol. 138.)

"Compulsory institutional treatment in a drug free environment is essential . . . !" (Ausubel, D. P.: op. cit.)

. Furnishing narcotics to addicts will not work to reduce the illegal traffic in narcotics since such proposals fail to take into account increased physiological tolerance.

8.

"It is one of the certain facts about heroin use that larger and larger doses are required, because of the peculiar mechanism of 'tolerance'. To get the desired effect the dose has to be steadily increased. Unless the 'clinic' is to sell the addict as much narcotics as he requests, he must go to illegal sources for the amount he wants," (Stephenson, G.H.: op. cit.)

. Dispensing narcotics to addicts will not reduce its allure.

"It greatly oversimplifies matters to attribute all of the glamour of drugs to their unlawful status: alcohol, cigarettes, cosmetics and automobiles are not illegal and still hold great fascination for youngsters." (Ausubel, D. P.: op. cit.)

"The argument that if drugs were legal they would lose their glamour and would not appeal to adolescents is very questionable. Legal sales of alcoholic beverages has not

made them unattractive to our youth. There is no reason to think that the predisposed persons who become today's addicts, and who became so in adolescence or early childhood, would not have become drug users if narcotics had been legally procurable. Supportive evidence for this assertion is that 75% of this series of narcotic addicts had already become heavy users of alcohol . . . even though alcohol was legally available." (Stephenson, G.HH.: op. cit.)

6. Furnishing narcotics to addicts would not undermine illegal drug traffic.

"In New York State alone when 16 or more narcotic clinics were in operation throughout the state, almost 4,000 ounces of narcotic drugs were seized in illicit channels during a year--or almost as much as was seized in the entire United States during 1952." (Anslinger and Tompkins: op. cit.)

7. Dispensing narcotics legally would not measurably prevent crime associated with drug use.

"There is very grave doubt that permitting addicts to receive drugs legally would actually result in good employment results or any sizeable diminution in crime. The 'narcotic clinic' experiment in the United States gave no support to these theories. Moreover, detailed studies of the employment and delinquency records of British Columbia addicts indicate that these poor records are not the result of narcotic use, but largely preceded their use of narcotics." (Stephenson, G. H.: op. cit.)

"It is possible that a proportion of addicts might do this (cease criminal activities). However, the basically hostile, anti-social psychopath could be expected to continue in his criminal activities regardless of whether or not he is receiving drugs." (Council of Mental Health, American Medical Association, op. cit.)

8. Furnishing narcotics to addicts would not enable such persons to lead otherwise socially useful lives.

"The belief that addicts whose drug demands are satisfied lead 'otherwise normal and productive lives,' is based on a myth which applies at most to a tiny fraction of the total addict population; namely, successful professional persons, usually physicians who take small doses to relieve anxiety. Most of these persons have long since switched to tranquilizers which are both more efficient for the purpose and not proscribed by law." (Ausubel, D. P.: op. cit.)

"The idea of establishing clinics for narcotic addicts where the addict can be furnished narcotics cheaply intrigues many people. Proponents of the idea naively assume that the person is quite normal as long as he can obtain narcotics. They should talk to doctor addicts who point out how their whole lives are meaningless except for one thing--and that is getting a shot four hours from now.

Family, children, friends, and patients mean nothing to them. For example, in delivering a baby they will nonchalantly cut through into the rectum with no sense of remorse whatsoever." (Quinn, William F., Narcotic Addiction in Physicians, Bulletin, Los Angeles County Medical Association, Vol. 88, No. 7, April 3, 1958).

9. Dispensing narcotics legally could be an infringement on the morality of society.

"Legalization would give drug addiction an unfortunate modicum of moral sanction that would encourage its spread among potential addicts." (Ausubel, D. P.: op. cit.)

"We believe the thought of permanently maintaining drug addiction with 'sustaining' doses of narcotic drugs to be utterly repugnent to the moral principals inherent in our laws and the character of our people." (Treatment and Rehabilitation of Narcotic Addicts, Report of the Committee on the Judiciary, U. S. Senate, containing findings of the Subcommittee on Improvements in the Federal Criminal Code, 84th Congress, 2nd Session, Rep. No. 1850, Washington, D. C., U. S. Government Printing Office, 1956.)

In summary, it should be mentioned that the United States Senate, the United States House of Representatives, the Canadian Senate and various state commissions have considered and rejected the idea of furnishing narcotics to addicts.

A TEST FOR ADDICTION

Section 11722 of the Health and Safety Code provides that when any person who has been a user of narcotics is granted parole, a condition of the parole may be that the parolee undergo periodic tests to determine, by means of the use of a synthetic opiate anti-narcotic, whether the probationer is a narcotic addict. Should the results of the test indicate that the probationer or parolee is an addict, his parole or probation may be voided and the individual returned to custody for further care.

A synthetic opiate anti-narcotic is a drug that has the effect of counteracting the physiological actions of morphine, heroin, and other morphine derivatives. The most frequently used opiate anti-narcotic has been nalorphine hydrochloride, commonly referred to as Nalline and chemically known as N-allylnormorphine hydrochloride.

Nalline is a white crystalline powder which, when dissolved in water, forms a clear colorless solution. In the field of medicine Nalline has three dissimilar uses as a narcotic antagonist. In obstetrics it may be used to prevent and treat depression of respiration and circulation in new-born infants whose mothers have received large doses of narcotics before birth of the child. Secondly, Nalline is used in the treatment of severe narcotic poisoning, such as when an addict has misjudged his tolerance or obtained a "fix" from an unexpectedly potent "bindle." Thirdly, it is used in testing for possible narcotic use.

Studies on previously addicted persons in the United States Public Health Center at Lexington, Kentucky, and on normal volunteers indicates the following: Small doses of nalorphine have been reported to produce pleasant relaxation and drowsiness, a sense of well-being and buoyancy, a sense of ill-being and dissatisfaction, day-dreams, constriction of the pupil of the eye, nausea, giddiness, sweating, inability to coordinate voluntary muscular movements, drooping of the eyelids, and vomiting. Larger doses of Nalline created the additional physical reactions of sweating, anxiety, and pressure of thoughts. The symptoms were often extremely unpleasant, but could be relieved by the administration of sodium pentobarbital. Unlike the narcotics, however, repeated administrations of nalorphine were not enjoyed by the post-addict and did not produce an abstinence syndrome on sudden withdrawal from the drug.

Conversely, when nalorphine is administered to persons addicted to narcotics, an entirely different effect has been observed. The typical effects in persons who are tolerant or addicted to narcotics are the sudden production of severe symptoms of abstinence. In addicts, abstinence indications could be precipitated within fifteen minutes after administration of the nalorphine. Peak effects occurred in forty-five minutes, and subsided over a period of several hours. The greater the tolerance or addiction to narcotics

the greater the severity of the abstinence symptoms produced by a given dose of nalorphine. A severe reaction might initially include an excessive dilation of the pupils of the eye, sweating, an abnormal rate of breathing, restlessness, nausea, and muscular aching caused by yawning, crying, nosebleed, and a protuberance of the skin around the hair follicles (gooseflesh). It was found that a very small dose of nalorphine administered just under the skin generally produces little more than dilation of the pupils and vague symptoms of discomfort.

In the normal individual, 3 mgs. of nalorphine subcutaneously (just under the skin) administered will usually cause constriction of the pupils by 0.5 mms. or more, cause mild depression, or parasymptomatic effects. On the other hand, an addicted person or a person who has been using narcotics within a relatively short period of time before the test will show pupillary dilation of $\frac{1}{2}$ mm. or more in addition to the aforementioned abstinence symptoms in varying degrees, depending upon the severity of the addiction. The changes in pupillary diameter are found to be sufficiently consistent to permit their use in determining narcotic use. Hence, the changes in pupil size form the basis of the narcotic addiction tests now being used in narcotic control and probation work.

To administer the test, consent of the suspect is first obtained. Before the first test is administered a personal history of the suspect is taken and he is given a physical examination. Fresh needle marks or other indications of addiction are noted. The pupil size is then measured by means acceptable to the field of medicine. Normally, 3 mgs. of nalorphine or 1.5 mgs. of levallorphan (Lorfan) are given subcutaneously. The pupil size is observed at 10 to 30 minute intervals for a minimum of 30 minutes for the signs and symptoms of non-addiction or addiction. Fixed light conditions exist during the entire test. A decrease of 0.25 mms. or more in diameter constitutes a negative test, indicating non-use, and an increase of 0.25 mms. is considered positive. When the change in the size of the pupil is less than 0.25 mms., the test is said to be equivocal.

With the view of determining the validity of the pupillary tests, the State Department of Justice entered into a contract with Drs. Henry W. Elliott and E. Leong Way of the Department of Pharmacology, School of Medicine, University of California, San Francisco, to correlate the morphine content of the urine and pupillary test results. A positive chemical test of morphine in urine indicates that an individual has taken morphine or heroin (due to the fact that heroin is rapidly and largely metabolized in the body, and is excreted in the urine chiefly as morphine or morphine products).

Data on pupil and chemical tests were correlated in a total of 183 out of 216 cases. Of the 183 cases analyzed, a total of 124 cases gave a negative test by both methods. In 13 cases, a positive test was obtained by both methods. In 12 cases, a positive chemical test was obtained when the pupillary test was negative.

A positive chemical test was obtained in 9 tests when the pupillary test was equivocal. In 12 equivocal chemical tests the pupil test was negative. In 13 cases where the chemical tests was reported to be negative, the pupil test indicated 8 cases as equivocal and 5 cases as positive.

In 137 cases there was complete agreement between the two procedures with respect to the negative and positive findings. In the 21 instances where the chemical test for morphine was positive and the pupil test was either negative or equivocal, the testers felt that the chemical test provided a more sensitive indication that the individual tested had been using heroin or morphine. They suggested that the individual had been using relatively little heroin or morphine for only a short period of time. In the 13 cases where the chemical test for morphine was reported to be negative and the pupil test positive or equivocal, the three more plausible explanations were: A narcotic substance other than morphine or heroin was injected which would not be detected by the chemical test employed. The pupil test may be a more sensitive indicator in certain individuals who have injected heroin or morphine for a long period of time who may have refrained from taking the drug for three or four days before the chemical test. The pupil test was unreliable under the conditions of the experiment.

It was the considered opinion of the testers that when the pupillary test is positive and the chemical test negative, the most likely explanation is that other narcotic substances may be present which are not detectable by the chemical test employed. However, in 8 cases where an equivocal test was obtained, the medical people were unable to obtain evidence of narcotic substances by chemical testing.

It should be noted that there are indications that the physical effects of nalorphine can be overcome, thereby negating the pupillary test. Preliminary investigations indicate, however, that it is very difficult for a narcotic user to deceive the doctor experienced in administering the nalorphine test. Further investigations are being undertaken in this area.

Nalline is <u>not</u> a cure for drug addiction, but rather a tool to be used in detecting the use of narcotic drugs. It is a generally accepted fact that there is no treatment for addiction other than complete abstinence, and this abstinence must be enforced where the addict will not or can not voluntarily submit to treatment.

The initial phase of the treatment must be conducted in a dope-free environment. This presents no particular problem. It is after the addict is released as "cured" the real problem begins--How do we keep him cured? Almost invariably upon discharge from the institution the former addict resumes the use of drugs and in very short order is once again an addict. Reports from federal and

state hospitals indicate that a very small percentage of patients discharged as cured remain cured. The great majority resort to the use of drugs within a comparatively short period of time. Obviously, the "cured" addict needs a strong incentive to remain cured. The mandatory Nalline test may provide this incentive.

Nalline testing programs have been instituted by the Department of Corrections and in several California communities. Nalline has been found to be an adequate tool when used as a detection device to indicate use of certain narcotics.

The nalorphine test could also be used as an enforcement tool to determine whether or not an individual is under the influence of a narcotic. However, because of the legal limitations which require the written consent of the person to be tested, there is a decided practical restriction on the usefulness of this test as an aid to enforcement officials.

Perhaps the effectiveness of the Nalline testing program can best be summarized by the statement of one old-time narcotic law enforcement officer who stated, "At best, Nalline will keep the addict from going back to the use of narcotics. At worst, it will keep him from developing an 'oil-burning habit' (i.e., a steady, continuous use of narcotics on a large scale)."

TRIPLICATE NARCOTIC PRESCRIPTION SYSTEM

The majority of individuals using narcotics illicitly are criminals first and then addicts. They are well aware that medicinal narcotics flowing through the normal channels which supply the medical profession constitute a far greater and more permanent supply than illicit trafficking could ever maintain. It is axiomatic, therefore, that the addict, when cut off by his illicit supplier, will turn to the procurement of medicinal narcotics.

The individual who diverts licit narcotics to illicit channels is an experienced criminal, cunning and audacious, who knows that federal and state laws allow only licensed physicians to prescribe narcotics--a fact, incidentally, which at all times encumbers the physician to the possibility of being the alternate and unwitting supplier of narcotics to gratify addiction. The possibility of a physician being victimized and of licit narcotics falling into the hands of the illicit user has long been recognized by the State lawmakers who, over a period of years, have passed a series of laws which have aided both the physician and the law enforcement officer.

The State Narcotic Act provides that certain narcotic drugs must be prescribed on official triplicate narcotic blanks. The prescribing of these drugs is controlled by a system developed in California and copied in Illinois. This system has been studied by several other states and by foreign countries. Narcotic experts who have conducted these studies have been quick to see the advantages to be derived and were unanimous in their praise of the system.

Simply stated, the system works as follows--official triplicate narcotic prescription blanks are provided free of charge to persons authorized to prescribe narcotics. When a narcotic requiring a triplicate prescription is prescribed, it is prepared on an official blank in triplicate. The prescriber retains a copy for his records; the original and one copy are given to the patient. When the patient has the prescription filled he gives the original and the copy to the druggist. After filling the prescription the druggist endorses the back of the copy, showing the date the prescription was filled, the name of the drug store, and the name of the pharmacist filling the prescription, retains the original in his files and sends the duplicate copy to the State Bureau of Narcotic Enforcement.

Personnel at the Bureau's Headquarters Office encode the prescriptions and punch the coded information onto IBM key punch cards. These cards are subsequently printed on monthly tabulation sheets, copies of which are sent to the Bureau's five field offices. These tabulation sheets list the name of the patient, the patient's city of residence, the serial number of the prescription, the narcotic registry number of the prescriber, and the quantity and type

of narcotic prescribed.

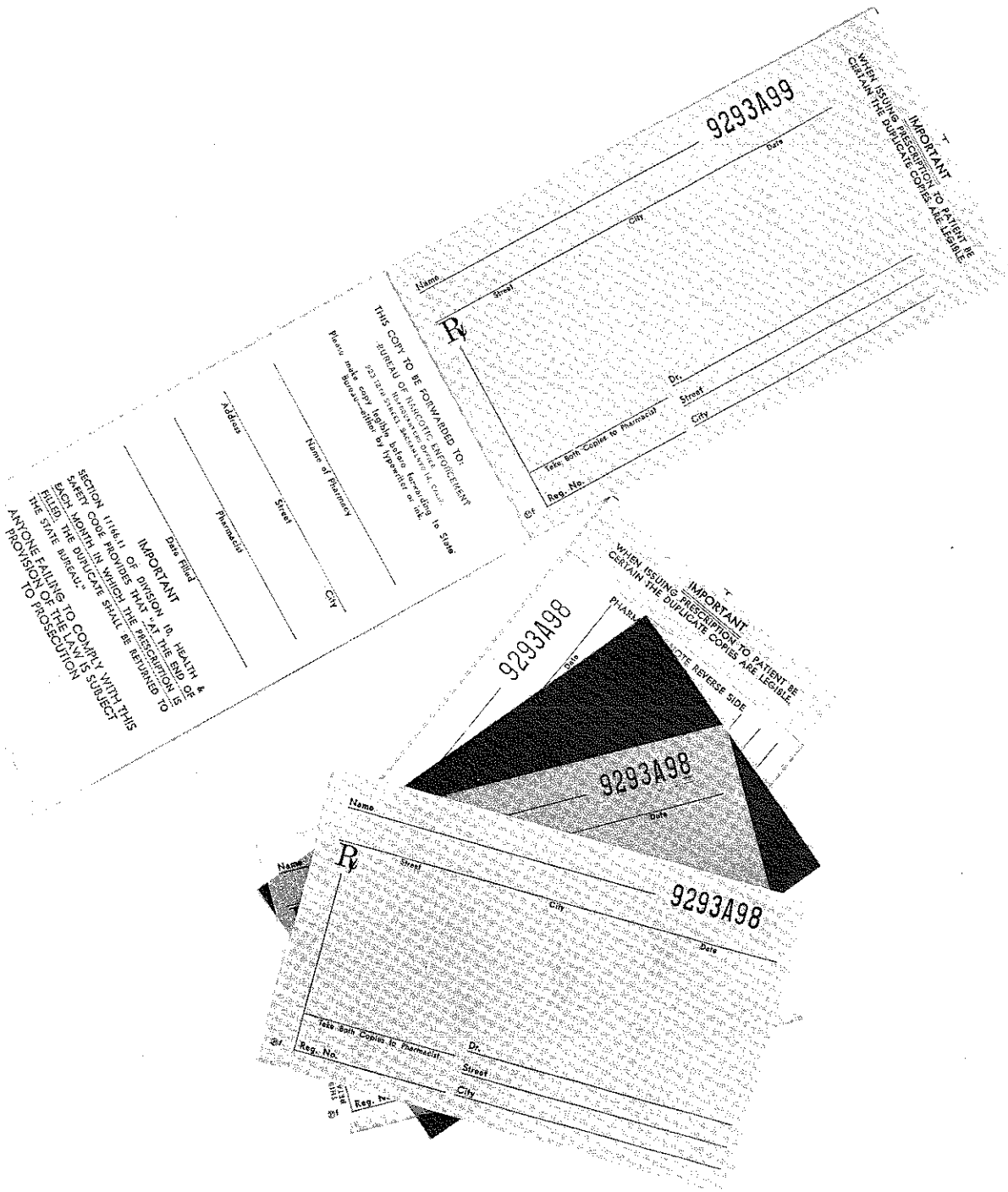
An examination of these tabulation sheets will uncover irregularities such as forgeries, fraudulent obtaining of narcotic drugs, and thefts of prescription blanks and their misuse by unauthorized persons. It will show if a patient has obtained prescriptions by going from doctor to doctor, or if there is a signature of an unregistered physician, and if blanks reported stolen from one person turn up in the hands of another. Such irregularities will form the basis for a complete investigation.

The effectiveness of the system is attested to by the 1960 arrest of a group which had been obtaining narcotic prescriptions under false pretenses from doctors on the West Coast. The group's method of operation was simple but effective. A member of the group, usually a woman, would enter the doctor's office and complain of severe pain. Normally the complaint was accompanied by a plausible excuse as to why the patient could not be given a thorough physical examination. Pending diagnosis, the physician would prescribe a narcotic drug to relieve the pain.

Over a period of two months the tabulation sheets showed the same persons obtaining narcotics from a number of different doctors. This, of course, aroused the suspicion of the State Narcotic Agents who immediately commenced an investigation which subsequently led to the arrest of the entire group.

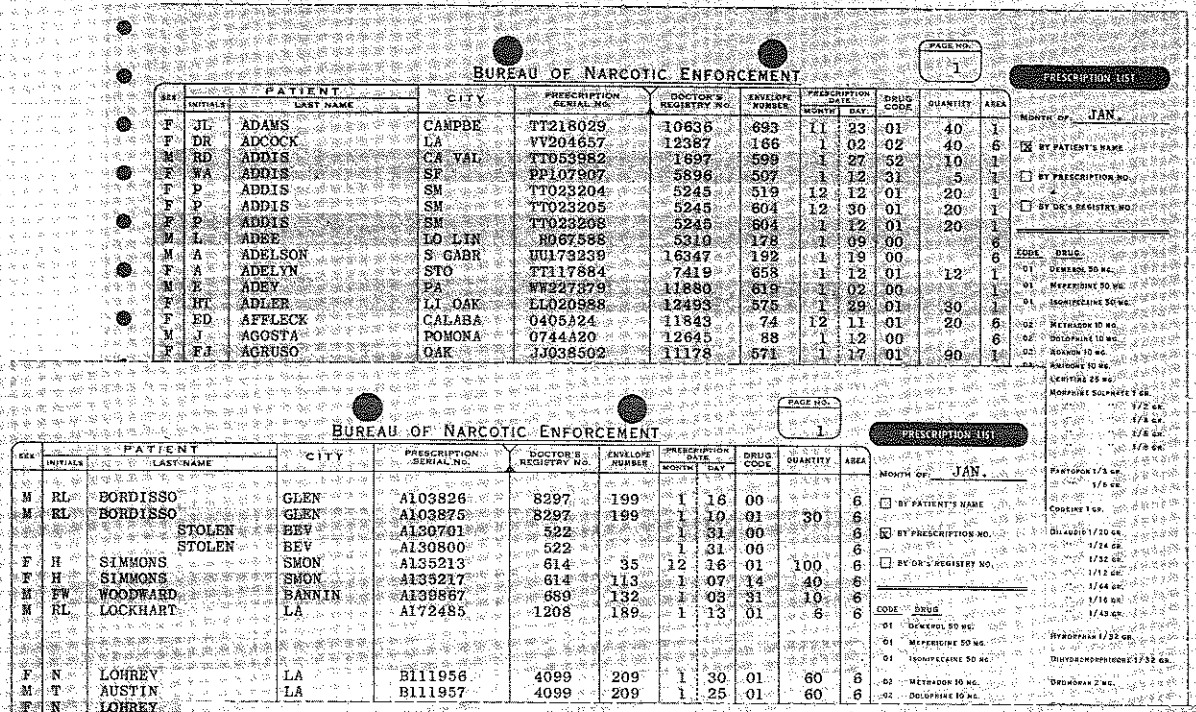
On questioning, the defendants revealed that by using the previously described method they had successfully obtained narcotics over the past several years in five different states. The leader of the group stated that had he known about the operation of the triplicate narcotic prescription system he would have stayed away from California.

Each year Agents of the Bureau of Narcotic Enforcement make numerous arrests of individuals who, in their attempts to obtain narcotics, have altered or falsified prescriptions which were issued to them in good faith by members of the medical profession. Without the Triplicate Narcotic Prescription System these arrests would not have been possible and the prescribing physicians, unknowingly, would have been the main source of supply for many addicts.



THE CALIFORNIA OFFICIAL TRIPLICATE NARCOTIC PRESCRIPTION BLANK

MONTHLY
NARCOTIC PRESCRIPTION
LISTINGS



BUREAU OF NARCOTIC ENFORCEMENT

PAGE NO. 1

PRESCRIPTION LIST

MONTH OF: JAN.

☒ BY PATIENT'S NAME

☐ BY PRESCRIPTION NO.

☐ BY DR.'S REGISTRY NO.

SEX	PATIENT INITIALS	PATIENT LAST NAME	CITY	PRESCRIPTION SERIAL NO.	DOCTOR'S REGISTRY NO.	ENVELOPE NUMBER	PRESCRIPTION DATE MONTH	PRESCRIPTION DATE DAY	DRUG CODE	QUANTITY	AREA
F	JL	ADAMS	CAMPBE	TT218029	10636	693	11	23	01	40	1
F	DR	ADCOCK	LA	VV204657	12387	166	1	02	02	40	6
M	RD	ADDIS	CA VAL	TT053982	1697	599	1	27	52	10	1
F	WA	ADDIS	SF	PP107907	5896	507	1	12	31	5	1
F	P	ADDIS	SM	TT023204	5245	519	12	12	01	20	1
F	P	ADDIS	SM	TT023205	5245	604	12	30	01	20	1
F	P	ADDIS	SM	TT023208	5245	604	1	12	01	20	1
M	L	ADEE	LO LIN	R067588	5310	178	1	09	00		6
M	A	ADELSON	S GABR	UU173239	16347	192	1	19	00		6
F	A	ADELYN	STO	TT117884	7419	658	1	12	01	12	1
M	E	ADEY	PA	WW227879	11880	619	1	02	00		1
F	HL	ADLER	LI OAK	LL020988	12493	575	1	29	01	30	1
F	ED	AFFLECK	CALABA	0405A24	11843	74	12	11	01	20	6
M	J	AGOSTA	POMONA	0744A20	12645	88	1	12	00		6
F	FJ	AGRUSO	OAK	JJ038502	11178	671	1	17	01	90	1

CODE — DRUG
01 DEMEROL 50 MG.
01 MEPERIDINE 50 MG.
01 ISONIPECAINE 50 MG.
02 METHADON 10 MG.
02 DOLOPHINE 10 MG.
02 ADANON 10 MG.
02 AMIDONE 10 MG.
03 LEVITINE 25 MG.
MORPHINE SULPHATE 1/2 GR.
" 1/3 GR.
" 1/4 GR.
" 1/6 GR.
" 1/8 GR.
PANTOPON 1/3 GR.
" 1/6 GR.
CODEINE 1 GR.
DILAUDID 1/30 GR.
" 1/24 GR.
" 1/32 GR.
" 1/12 GR.
" 1/64 GR.
" 1/16 GR.
" 1/48 GR.
HYDROPHAN 1/32 GR.
DIHYDROMORPHINONE 1/32 GR.
DROMORAN 2 MG.

BUREAU OF NARCOTIC ENFORCEMENT

PAGE NO. 1

PRESCRIPTION LIST

MONTH OF: JAN.

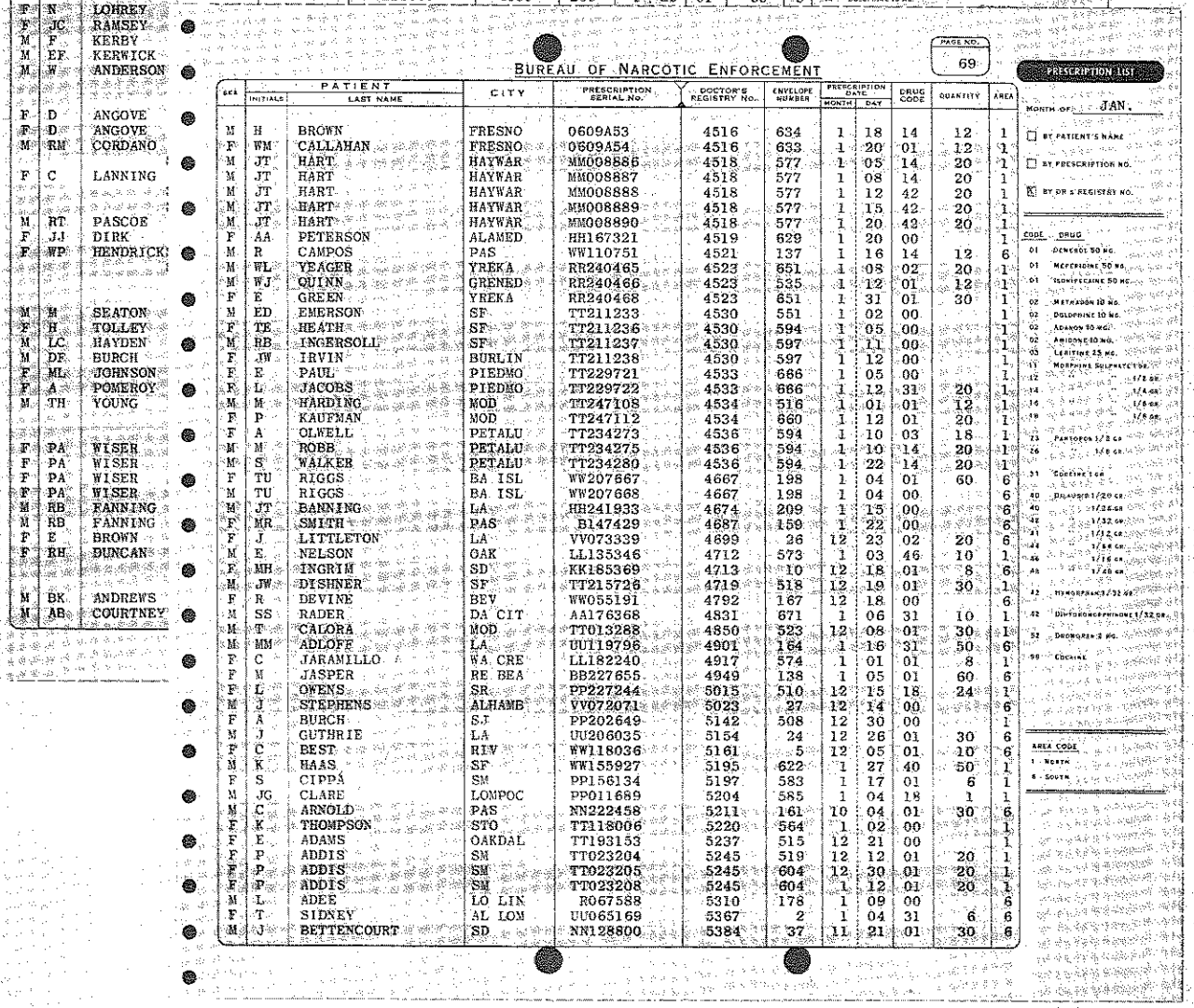
☐ BY PATIENT'S NAME

☒ BY PRESCRIPTION NO.

☐ BY DR.'S REGISTRY NO.

SEX	PATIENT INITIALS	PATIENT LAST NAME	CITY	PRESCRIPTION SERIAL NO.	DOCTOR'S REGISTRY NO.	ENVELOPE NUMBER	PRESCRIPTION DATE MONTH	PRESCRIPTION DATE DAY	DRUG CODE	QUANTITY	AREA
M	RL	BORDISSO	GLEN	A103826	8297	199	1	16	00		6
M	RL	BORDISSO	GLEN	A103875	8297	199	1	10	01	30	6
		STOLEN	BEV	A130701	522		1	31	00		6
		STOLEN	BEV	A130800	522		1	31	00		6
F	H	SIMMONS	SMON	A135213	614	35	12	16	01	100	6
F	H	SIMMONS	SMON	A135217	614	113	1	07	14	40	6
M	FW	WOODWARD	BANNIN	A139867	689	132	1	03	31	10	6
M	RL	LOCKHART	LA	A172485	1208	189	1	13	01	6	6
F	N	LOHREY	LA	B111956	4099	209	1	30	01	60	6
M	T	AUSTIN	LA	B111957	4099	209	1	25	01	60	6
F	N	LOHREY									
F	JC	RAMSEY									
M	F	KERBY									
M	EF	KERWICK									
M	W	ANDERSON									
F	D	ANGOVE									
F	D	ANGOVE									
M	RM	CORDANO									
F	C	LANNING									
M	RT	PASCOE									
F	JJ	DIRK									
F	WP	HENDRICK									
M	M	SEATON									
F	H	TOLLEY									
M	LC	HAYDEN									
M	DE	BURCH									
F	ML	JOHNSON									
F	A	POMEROY									
M	TH	YOUNG									
F	PA	WISER									
F	PA	WISER									
F	PA	WISER									
F	PA	WISER									
M	RB	FANNING									
M	RB	FANNING									
F	E	BROWN									
F	RH	DUNCAN									
M	BK	ANDREWS									
M	AB	COURTNEY									

CODE — DRUG
01 DEMEROL 50 MG.
01 MEPERIDINE 50 MG.
01 ISONIPECAINE 50 MG.
02 METHADON 10 MG.
02 DOLOPHINE 10 MG.



BUREAU OF NARCOTIC ENFORCEMENT

PAGE NO. 69

PRESCRIPTION LIST

MONTH OF: JAN.

☐ BY PATIENT'S NAME

☐ BY PRESCRIPTION NO.

☒ BY DR.'S REGISTRY NO.

SEX	PATIENT INITIALS	PATIENT LAST NAME	CITY	PRESCRIPTION SERIAL NO.	DOCTOR'S REGISTRY NO.	ENVELOPE NUMBER	PRESCRIPTION DATE MONTH	PRESCRIPTION DATE DAY	DRUG CODE	QUANTITY	AREA
M	H	BROWN	FRESNO	0609A53	4516	634	1	18	14	12	1
F	WM	CALLAHAN	FRESNO	0609A54	4516	633	1	20	01	12	1
M	JT	HART	HAYWAR	MM008886	4518	577	1	05	14	20	1
M	JT	HART	HAYWAR	MM008887	4518	577	1	08	14	20	1
M	JT	HART	HAYWAR	MM008888	4518	577	1	12	42	20	1
M	JT	HART	HAYWAR	MM008889	4518	577	1	15	42	20	1
M	JT	HART	HAYWAR	MM008890	4518	577	1	20	42	20	1
F	AA	PETERSON	ALAMED	HH167321	4519	629	1	20	00		1
M	R	CAMPOS	PAS	WW110751	4521	137	1	16	14	12	6
M	WL	YEAGER	YREKA	RR240465	4523	651	1	08	02	20	1
M	WJ	QUINN	GRENED	RR240466	4523	535	1	12	01	12	1
F	E	GREEN	YREKA	RR240468	4523	651	1	31	01	30	1
M	ED	EMERSON	SF	TT211233	4530	551	1	02	00		1
F	TE	HEATH	SF	TT211236	4530	594	1	05	00		1
M	RB	INGERSOLL	SF	TT211237	4530	597	1	11	00		1
M	JW	IRVIN	BURLIN	TT211238	4530	597	1	12	00		1
F	E	PAUL	PIEDMO	TT229721	4533	666	1	05	00		1
F	L	JACOBS	PIEDMO	TT229722	4533	666	1	12	31	20	1
M	M	HARDING	MOD	TT247108	4534	516	1	01	01	12	1
F	P	KAUFMAN	MOD	TT247112	4534	660	1	12	01	20	1
F	A	OLWELL	PETALU	TT234273	4536	594	1	10	03	18	1
M	M	ROBB	PETALU	TT234275	4536	594	1	10	14	20	1
M	S	WALKER	PETALU	TT234280	4536	594	1	22	14	20	1
F	TU	RIGGS	BA ISL	WW207667	4667	198	1	04	01	60	6
M	TU	RIGGS	BA ISL	WW207668	4667	198	1	04	00		6
M	JT	BANNING	LA	HH241933	4674	209	1	15	00		6
F	MR	SMITH	PAS	B147429	4687	159	1	22	00		6
F	J	LITTLETON	LA	VV073339	4699	26	12	23	02	20	6
M	E	NELSON	OAK	LL135346	4712	573	1	03	46	10	1
F	MH	INGRIM	SD	KK185369	4713	10	12	18	01	8	6
M	JW	DISHNER	SF	TT215726	4719	518	12	19	01	30	1
F	R	DEVINE	BEV	WW055191	4792	167	12	18	00		6
M	SS	RADER	DA CIT	AA176368	4831	671	1	06	31	10	1
M	T	CALORA	MOD	TT013288	4850	523	12	08	01	30	1
M	MM	ADLOFF	LA	UU119796	4901	164	1	18	31	50	6
F	C	JARAMILLO	WA CRE	LL182240	4917	574	1	01	01	8	1
F	M	JASPER	RE BEA	BB227655	4949	138	1	05	01	60	6
F	L	OWENS	SR	PP227244	5015	510	12	15	18	24	1
M	J	STEPHENS	ALHAMB	VV072071	5023	27	12	14	00		6
F	A	BURCH	SJ	PP202649	5142	508	12	30	00		1
M	J	GUTHRIE	LA	UU206035	5154	24	12	26	01	30	6
F	C	BEST	RIV	WW118036	5161	5	12	05	01	10	6
M	K	HAAS	SF	WW155927	5195	622	1	27	40	50	1
F	S	CIPPA	SM	PP156134	5197	583	1	17	01	6	1
M	JG	CLARE	LOMPOC	PP011689	5204	585	1	04	18	1	1
M	C	ARNOLD	PAS	NN222458	5211	161	10	04	01	30	6
F	K	THOMPSON	STO	TT118006	5220	564	1	02	00		1
F	E	ADAMS	OAKDAL	TT193153	5237	515	12	21	00		1
F	P	ADDIS	SM	TT023204	5245	519	12	12	01	20	1
F	P	ADDIS	SM	TT023205	5245	604	12	30	01	20	1
F	P	ADDIS	SM	TT023208	5245	604	1	12	01	20	1
M	L	ADEE	LO LIN	R067588	5310	178	1	09	00		6
F	T	SIDNEY	AL LOM	UU065169	5367	2	1	04	31	6	6
M	J	BETTENCOURT	SD	NN128800	5384	37	11	21	01	30	6

CODE — DRUG
01 DEMEROL 50 MG.
01 MEPERIDINE 50 MG.
01 ISONIPECAINE 50 MG.
02 METHADON 10 MG.
02 DOLOPHINE 10 MG.
02 ADANON 10 MG.
02 AMIDONE 10 MG.
03 LEVITINE 25 MG.
MORPHINE SULPHATE 1/2 GR.
" 1/3 GR.
" 1/4 GR.
" 1/6 GR.
" 1/8 GR.
PANTOPON 1/3 GR.
" 1/6 GR.
CODEINE 1 GR.
DILAUDID 1/30 GR.
" 1/24 GR.
" 1/32 GR.
" 1/12 GR.
" 1/64 GR.
" 1/16 GR.
" 1/48 GR.
HYDROPHAN 1/32 GR.
DIHYDROMORPHINONE 1/32 GR.
DROMORAN 2 MG.
COCAINE

AREA CODE
1 - NORTH
6 - SOUTH

NARCOTIC SLANG

Bindle	A small packet of heroin, morphine, or cocaine.
Black	Opium.
Blast	To smoke a marihuana cigarette.
Blow	To smoke a marihuana cigarette.
Bread	Money. Substitute for "Dough."
Brick	Kilo of marihuana in compressed brick form.
Burn	To accept money and give no narcotic in return, or to give a substance in lieu of.
Burned out	The sclerotic condition of the vein present in most conditioned addicts.
Can (of marihuana)	Term derived from Prince Albert Tobacco can in which marihuana was commonly sold in the past. Now more frequently observed in small paper bags.
Cap	A capsule of heroin, commonly a number 5 gelatin capsule.
Chippy	An occasional user of heroin.
Clean	Refers to removing stems and seeds from marihuana. Also an addict who is free from narcotic injection marks, as in "I'm clean, Man."
Coke	Cocaine.
Cold turkey	The method of curing drug addiction whereby an addict is taken off drugs with no tapering-off period.
Connect	To buy drugs.
Connection	A peddler who knows an addict and will sell him drugs.
Cottons	Bits of cotton saturated with narcotic solution used to strain foreign matter when drawing solution up into hypodermic syringe or eyedropper. These cottons are often saved by addicts for an emergency, as they contain a residual amount of the drug.
Cut	To adulterate narcotics.
Crutch	Device used to hold marihuana cigarette when it has burned to the point where it will burn the fingers. Also a container for a hypodermic needle.
Dealer	A drug peddler.
Deck	A small packet of morphine, cocaine, or heroin.
Dope	Any narcotic.
Fit	(See "Outfit".)
Fix, fix-up	A drug which is about to be injected, or has just been injected.
Fuzz	The law.
Gram	Gram of heroin (approximately 10 capsules).
Grass	Marihuana in the raw state, leaves, stems, etc.
Grasshopper	Marihuana user.
Gun	(See "Outfit.")
H	Heroin.
Habit	Addiction to drugs.
Hand-to-hand	Delivery of narcotics person-to-person.
Hay	Marihuana.
Head	Marihuana user.

Heat	The law.
High	Under the effect of narcotics, usually only used in relation to cocaine and marihuana.
Hog	An addict who uses all he can get his hands on.
Holding	Possessing narcotics.
Hooked	Addiction, stage following physical dependence, a confirmed addict.
Horning	Sniffing narcotics up nose.
Hype	An addict using the injection route.
Joint	A marihuana cigarette. Also State Prison.
Jolt	An injection of narcotics.
Joy Pop	An occasional injection of narcotics. One who is "joy popping" only takes an injection now and then.
Junk	Any kind of narcotics, but since heroin is the drug most common to today's illegal traffic, it is now used generally in reference to heroin.
Kicking (the habit)	Trying to break the habit. "Kicking it cold turkey" is breaking the habit of drug use at home, in prison, etc., without the aid of any medication or medical care.
Kee	2.2 lbs.
Kilo	2.2 lbs.
Lid	(See "Can.")
Loaded	Under influence of heroin.
Main-line	Veins of body, usually arms; also intravenous injection.
Main-liner	One who injects narcotics directly into the veins, intravenously.
Man (the)	Law - Connection - used to start a sentence, etc.
Manicure	Prepare marihuana for use in cigarettes.
Narco	Narcotic officer.
Outfit	Equipment for injection by the hypodermic route, a "hype" outfit. Hypodermic syringe and needle, spoon, safety pin, razor, etc.
Panic	A scarcity of drugs, usually caused by the arrest of a big peddler.
Piece	One ounce of narcotics.
Pig	See "Hog."
Pill Head	Amphetamine or barbiturate user.
Pill Freak	(See "Pill Head.")
Pilly	(See "Pill Head.")
Pop	A subcutaneous injection, usually referred to as "skin popping."
Pot	Marihuana.
Pure (the)	Pure heroin, prior to adulteration. "This is the pure, you can cut it ten times at least."
Pusher	Drug peddler to users. One who seeks more business from regular customers, and who seeks new customers himself or through a recruiter.
Roach	A partially consumed marihuana cigarette.
Scoring	Making a purchase of narcotics.
Shooting gallery	A place where an injection of narcotics can be bought, but which does not permit loitering.

Shot	An injection of narcotics.
Smack	Drugs, especially powdered drugs in the form of snuff.
Sniffing (snorting)	Using narcotics by sniffing up the nose, usually heroin or cocaine. This is taking it "rare"--not in solution.
Snow	Cocaine.
Snowbird	Cocaine user.
Speed ball	A shot of heroin and cocaine combined.
Spike	A hypodermic needle.
Spoon	A quantity of heroin theoretically measured in a teaspoon (usually between 1 and 2 grams).
Square	Does not know what's happening.
Stash	Place where narcotics or the "outfit" is hidden; also place where a drug peddler will secrete various quantities of narcotics. In a "hide-out" purchase the drug peddler accepts the money and then tells the drug user where the narcotics are hidden and the user then goes to the "hide-out" and picks up his purchase.
Stick	Marihuana cigarette.
Stoned	Under the influence of drugs.
Straight	A person holding, or under influence of narcotics.
Strung out	Addicted (heavily).
Stuff	Heroin.
T	Marihuana.
Taste	A small sample of a narcotic.
Tea	Marihuana.
Tea-head	A marihuana smoker.
Toke-up	To light a marihuana cigarette (they burn much more brightly than an ordinary cigarette--"torch" is also being used in the East for a "marihuana cigarette").
Turn on	To use narcotics for the first time or to introduce another person to the use of narcotics. Also, the act of using narcotics or to furnish narcotics to another individual.
User	One who uses heroin.
Weed	Marihuana; a "weed-head" is a marihuana smoker.
White stuff	Heroin or morphine (don't confuse with "snow"--cocaine).

NON-NARCOTIC VERNACULAR PERTAINING TO BARBITURATES AND NON-NARCOTIC DRUGS

Bennies	Benzedrine.
Blue heaven	Amytal.
Dexies	Dexedrine.
Goof ball	Any barbiturate tablet or capsule.
Goofed up	Under the influence of barbiturates.
Rainbow	Tuinal.
Red devil or redbird	Seconal.
Yellowjacket	Nembutal.

OBSOLETE TERMS
(May be encountered with older addicts)

Bang	The thrill in drug taking. Also to inject with a drug.
Buzz	The effect of a drug.
Cube	A cube of narcotics, usually morphine, generally 3 to 4 grains.
Gong	An opium pipe.
Gong-beater	Smoker of opium.
Hop	Drugs, especially opium.
Hop head	A narcotic addict; originally an opium addict.
Mud	Opium for smoking.
Sleigh ride	Using "snow"--cocaine.
Toy	The smallest container of prepared opium.
Yen	Craving for narcotics. A "burning yen" is a marked craving.
Yen-hok	A long steel needle upon which an opium pill is cooked.
Yen-pock	A ration of opium prepared for smoking.
Yen-shee	The residue left in the opium pipe's bowl and stem after the opium has been smoked.
Yen-shee doy	Chinese. A Chinese drug addict.
Yen-shee gow	A scraper for removing yen-shee from the opium pipe.
Yen-shee suey	Opium wine. Yen-shee mixed with water or whiskey.

SELECTED BIBLIOGRAPHY

Anslinger, Harry J.
"Drug Addiction"
Encyclopedia Britannica (14th ed.), VII, 678-79.

A good, concise description of narcotic drugs, their effects, types of addicts, and the laws governing resale and possession of narcotics.

Ausubel, David Paul
"Drug Addiction: Physiological, and Sociological Aspects." New York, Random House, 1958, 126 pp. (Studies in Psychology, No. pp 17.)

Explanation of need for an integrated treatment of drug addiction that embraces all of its multifaceted aspects--pharmacological, psychiatric, psychological, sociological, and educational. A fully documented interpretation of research findings in the field of drug addiction. Non-technical style.

California State Narcotic Act
Division 10 of the Health and Safety Code--Narcotics.

Of particular interest to doctors, pharmacists, and law enforcement officials. Available from Bureau of Narcotic Enforcement.

DeRopp, Robert S.
"Drugs and the Mind." New York, St. Martin's Press, 1957. 310 pp.

An explanation of ancient and new drugs, covering all aspects, their effect on the brain and emotions, their potentialities for good and evil. How addicts are addicted. How sick minds are helped with new drugs. Drug addiction concerning the future.

Deutsch, Albert
"What We Can Do About the Drug Menace." 3rd ed. New York, Public Affairs Commission, 1958, 32 pp. (Public Affairs Pamphlet, No. 186) 22 East 38th Street, New York.

Suggestions offered to the public to help control and eliminate the narcotic problem through education in schools and home.

Final Report of The Special Study Commission on Narcotics--1961.
A report to the Governor of California on the existing narcotic and dangerous drug situation. Includes recommendations, many of which have since been enacted into law. Excellent for layman or peace officer.

Howe, Hubert Shattuck
"Narcotics and Youth"; West Orange, N. J., Brook Foundation, 1953, 40 pp. (Address: 51 Lakeside Ave., West Orange, N. J.)

A doctor discusses the problem of teen-age addiction and its effects. Excellent discussion with case histories.

Los Angeles Police Department
"Youth and Narcotics," rev. ed., Los Angeles, Los Angeles Police Department, 1953, 24 pp.

Deals with Los Angeles Juvenile problems in narcotics. Explains paraphernalia needed by the addict. Now out of print but obtainable in modified form from The Narcotic Educational Foundation of America; Address: 5055½ West Sunset Boulevard, Los Angeles, California. This is a non-profit organization dedicated to the dissemination of information on all phases of narcotics, including dangerous drugs.

Maurer, David W. and Victor H. Vogel
"Narcotics and Narcotic Addiction." Springfield, Ill., Thomas, 1954, 303 pp. (American Lecture Series, Publication No. 169.)

Considered the most authoritative in the field. Written from a medical standpoint. Good background material for an investigation of narcotics.

New York (City) Board of Education
"What Secondary Schools Can Do About Narcotics Addiction." New York, 1957. 27 pp. (Curriculum Bulletin, 1956-57, No. 3.)

Sales Office, 110 Livingston St., Brooklyn, New York. Pamphlet was prepared by Board of Education, Department of Health, Police Department of New York, for use by teachers in secondary schools as a supplement to courses of study. Covers extent of narcotic teaching program used, detection, referral and treatment; role of school personnel and desired outcomes.

Rathbone, Josephine L.
"Tobacco, Alcohol and Narcotics," New York, Oxford Book Co., 71 Fifth Ave., 1952, 72 pp.

An excellent discussion of the effects of these items on the human organism; written for teen-agers.

St. Charles, Alwyn J.
"The Narcotic Menace," Los Angeles, Borden Pub. Co., 1952, 206 pp.

The principal motive for this book is to provide schools, parents, students and others interested in the subject of narcotics, a

reliable source of information covering the chief topics of this all-important problem. A police officer's experience with the dope menace in the United States. Emphasis is on experience in Los Angeles. A good "first" for laymen.

Smith, Austin E.
"Drug Habit," World Book Encyclopedia, 1961 ed., IV, 289.
"Narcotic," World Book Encyclopedia, 1961 ed., XIII, 20.

Simple, short discussions of narcotic drugs and their effects.

United Nations
"The United Nations and Narcotics Drugs," United Nations, New York, United Nations Review Reprint, 1959.

Pamphlet discussing cooperation between nations of the world in suppressing narcotic drugs. What functions are achieved by the different foreign countries banding together as one against the illicit smuggling of drugs.

U. S. Bureau of Narcotics
"Living Death, Truth About Drug Addiction," Washington, Government Printing Office, 1956, 5 pp.

Pamphlet containing essential facts about drug addiction. Physical effects, how to avoid becoming an addict. Other results of narcotic addiction.

U. S. Congress, Senate, Committee on the Judiciary
"Illicit Narcotics Traffic," Washington, U. S. Government Printing Office, 1956, 9 pp., (84th Congress, 2nd session, Senate, Report No. 1440).

Report of the Committee on the Judiciary, United States Senate, containing a summary of Preliminary Findings and Recommendations of the Subcommittee on Improvements in the Federal Criminal Code, Pursuant to S. Res. 67.

Vogel, Victor Hugh, and Virginia E. Vogel
"Facts About Narcotics," Chicago, Science Research Associates, 1951, 49 pp., (Life Adjustment Booklet), Address: 57 W. Grand Ave., Chicago 10, Illinois.

A short non-technical study of the history, addiction, harmful effects, laws, treatments of drug addiction. Good for teen-age reading.