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HEROIN--MYTHS AND KNOWLEDGE: IMPACT ON PUBLIC POLICY

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ABSTRACT: Public Policy in the United States towards the heroin user and addict has been punitive as well as unsuccessful in deterring drug use or in treatment of the addict. Bias, myths, and prejudices have influenced our policy stance and have made heroin addiction a more serious problem than it otherwise would have been. This is explicated in the article, and contrasted with the British system which in attitude and practice tends to view the addict as ill rather than evil.

Since quite early in this century, in the United States, "...we have built our drug control policies around the twin judgments that drug abuse was an evil to be suppressed and that this could most effectively be done by application of criminal enforcement, and penal sanctions." (President's Commission on Law Enforcement and Administration of Justice, 1967:222) As a particular result of this, there is intense debate about each new policy initiative because of the widely held opinions and attitudes about heroin usage and crime. "Attitudes ... have considerable bearing on the formulation and implementation of public policies. American attitudes ... generally are punitive." (Shur, 1964:80)

In a process that started over sixty years ago when narcotic use was first repressed by the Harrison Act, these attitudes have led to the ostracism of the chronic drug user. "From being regarded as a deviant, the user became a criminal, then a diseased person, and now a criminally diseased deviant. Addicted, still experienced as an abuse to the American self image ... the drug user remains the archetypal pariah." (Lewis, 1976:32) The condemnation of drug use, and the drug user, often is emotional and powerful.

Zinberg and Robertson (1972:14) state accurately that "The public wields fearsome power; by condemning drug use so violently, it has made it a much more serious matter than it would otherwise have been. On the other hand, Roffman (1972:23) indicated that "... it is the policies - not heroin - that have caused such a false perception of the phenomenon that has come to be a major social problem."

Repressive laws, the expression of our attitudes and policies on drug use have not effectively served as a deterrent. (New York Times, April 4, 1976, Sec. 5, page 5) As an example of this, in New York State a much heralded harsh law enacted by Governor Rockefeller in 1973 was dismantled because it was not working, seemed unenforceable, and was clogging the courts with minor offenders (New York Times, July 2, 1976:A10). Our society tends to want simplistic, familiar solutions, such as the Rockefeller law, rather than address itself to the doubts and ambiguities that are present in as complex an issue as drug use. It would be helpful in formulating policy to understand the increase in contemporary drug use and addiction. No one has suggested a fully accepted theory to explain the increase, but many have been put forth.

Wilson et al referred to four speculative possibilities that may have caused the increase in heroin use: (1) the rise in real income during the 1960's may have made it possible to spend more on heroin, just as one could buy more automobiles. (2) The emphasis on personal liberation among the young resulted in greater freedom in dress, mores, the development of a rock culture, and perhaps to greater experimentation with heroin. (3) The war in Vietnam, when soldiers had easy access to drugs, and the alienation, fear and demoralization associated with that experience may have been factors that led to experimentation. (4) The continued disintegration of lower-income, especially Black family life may have strengthened the importance of a peer group in a social environment conducive to heroin experimentation. (Wilson, Moore and Wheat, 1972:6) Isadore Chein et al (1964) described three pressures influencing people in the direction of drug use: the attempt to preserve self-esteem in the face of inadequacy for adult roles, the desire for certain kinds of intense personal relationships, and rebellious feelings against existing social standards. The National Commission on Marijuana and Drug Abuse (1973:100-101) commented that drug use is cyclical, and addressed itself to the broad cultural influences on drug use. They said that acquisition of material wealth has been attained by many, and is no longer a guiding purpose to those lives. Leisure time is considerable with little meaningful activity to fill it. The poor in the midst of affluence also have leisure time, but of a different and demeaning order. The Commission commented on the loss of community, and the loss of the values of that community. For the young, since all the frontiers are settled, the only place left to search is inside themselves, which may be the most difficult endeavor of all.

Some, or all of these speculations on the rise of heroin use may be correct. Their range and diversity, however, illustrate the difficulty in creating policy based on a clear understanding of the reasons for

increased heroin use. One assumption is accepted widely. Heroin produces euphoria, at least in the early stages of addiction, the "honeymoon state." The addict is loath to give up the pleasure associated with this experience. This relates to the reasons heroin addiction does not succumb easily to either treatment or incarceration. "Another point worth considering deals with the realistic number operable or motivated for intense in-patient treatment. There are many aspects of the street life valued by the addict which block his desire for treatment such as 'it feels good,' criminal associations, peer group reinforcement ... I would estimate that conservatively 80 percent were not seriously interested in working on changing their lives away from drugs." (Brewster, 1972:19) Brill (1963:155) also commented that the addict, "in many cases ... frankly states that he prefers this life with heroin, and his chief ambition is to have a plentiful supply." Furthermore, there is more chance for treatment success with the old 'hardened' addict who may be taking his drug presumably to ward off the pain of withdrawal. "It is recognized that treatment difficulties are inversely related to age and that the most difficult cases are teen-aged addicts and those in the early twenties; moreover, those of more mature years are easier to treat and also have a better prognosis, probably due to maturing out." (Brill, 1963:156)

Another of the common fallacies which tend to be accepted, and therefore influence policy is that of the contagion model of addiction. This model posits a carrier, usually a young addict, who still is euphoric. He is carrying the communicable disease of heroin-addiction, and he affects all of those close friends with whom he has contact. This situation usually is referred to as an epidemic. Some of the writing about this is inflammatory, and designed to create great fear. As one example, Dr. Densen-Gerber (1973:371) wrote:

For heroin addiction, as is the case with other communicable diseases, knows no boundaries, and no one is safe. The white plague spreads with the same rapidity and virulence in the 20th Century that the Black Plague did in the 17th Century - only there is no countryside for the rich to fall to for refuge, and as yet, no great fire to burn the pestilence to the ground. But heroin is only the herald of the holocaust to come ...

Some research is based on this model, and then it is justified in scientific terms. "If drug abuse is seen as a practice that is transmitted from one person to another, it can be considered for operational purposes as a contagious illness. This approach makes it possible to apply to its study the methods and terminology

used in the epidemiology of infectious diseases." (DeAlarcon, 1969:21) The problem with this line of thinking is that acceptance of the communicable disease -- contagion model, leads to the acceptance of the idea of heroin use as an epidemic, which if carried to its logical end would lead to a mass quarantine to limit the contagion. Furthermore it perhaps could lead to preventive detention of dependency prone individuals. (Bayer, 1974:304)

Fortunately, communicating behavior cannot accurately be equated with the spread of a virus. "The fatal flaw in the contagion analogy ... is the victim's consent. With truly infectious diseases, the victim does not want to contact the disease." (National Commission on Marijuana and Drug Abuse, 1973:27) Indeed, as the Commission and other commentators have pointed out, one doesn't decide to contact smallpox from an associate or intimate, but we do choose to accept heroin from a friend. Indeed, it is often requested. (Feldman, 1970:3-10) "... the 'peer-victim' chooses to use a drug, in most cases he probably is eager to try it, notwithstanding the risk of dependence. Furthermore, heroin users are most 'contagious' in their first year of use before they are dependent to any significant degree ... upon becoming heartily involved in drug taking behavior, their 'infectious' days are over; they are now withdrawn and unlikely to be proselytizing. Thus, assertion of control over drug dependent persons ... is unlikely to have any impact upon the incidence of use." (National Commission on Marijuana and Drug Abuse, 1973:271).

It would be helpful indeed, if we recognized that, "The spread of drug addiction is associated with human misery, and not any intrinsic contagiousness." (Chein, 1964:328) The contagion model, then is fallacious, and policy based upon it would be specious. It persists, however, along with other powerful myths and misconceptions. Another myth frequently expressed is that all pushers try to induce young children, pre-adolescents, into the nether world of drug abuse. It is true enough that some individuals do commence their drug careers as early as their eleventh or twelfth years. "Nevertheless, it is an unfounded belief that pushers stand on corners, near schools ... offering heroin filled candy ... to little children. The pusher will not force his victim into an alley, hold him down and insert a syringe into his arm to create another addict. This is not economically feasible ... just as no one is distributing free gold, no one is giving away free heroin." (Gubar, 1968:30)

Another area of confusion in the mind of many is the connection between crime and heroin use. Just as the conventional wisdom indicates that pushers induce youngsters to try heroin, it also

indicates that as a result of this induction, he will be driven to a life of crime to support his habit.

In fact, there are few who will not agree that there is a strong association between addiction and crime. The question is whether there is a causal relationship between them and if so, in which direction. John O'Donnell referred to this question and he specified four major positions (1969 (A):71-72) as follows: (1) Some such as Harold Finestone (1957:69-85) denied that there was any causal relationship since both addiction and crime are effects of the same set of social conditions. (2) Another position, fortunately only of historical interest at this time, indicated that the addiction caused the crime because of the deterioration of the character of the drug taker and/or as a direct categorical effect of the drug. (Anslinger and Tompkins, 1953) (3) The third indicates that addiction is primarily a later stage in a criminal career. Indeed, this has been well researched and the available data indicates that most known heroin users had delinquent or criminal histories before they were identified as drug users. (For example, see Blum, 1967, and O'Donnell, 1969 (B)) (4) There is a fourth position that it is society's manner of handling addiction that has made it a cause of crime. (Lindsmith, 1967)

There is no question that the laws making heroin use criminal have made it expensive. Also, the fact that individuals had been involved in criminal behavior before addiction does not negate in any way the criminogenic effects of opiate use, once the individual is addicted. Various observers have commented on the necessity to use crime to support a habit, and the association is accepted widely. (For example, Cushman, 1971 and Preble and Casey, 1969)

"The issue today is mainly between the proponents of the last two positions, one holding that addicts would have become criminals whether or not they had become addicted, the other that they would not have been criminals if they had not become addicted and had not been labeled as such ... both positions are usually overstated." (O'Donnell, 1969 (A):72) Both positions may have many elements of accuracy. We know that many addicts would have been criminals anyway, and it is quite probable that many others would have avoided crime if it were not for the criminogenic effects of its use in this society. It is, of course, most difficult, if not impossible to produce any evidence for the latter statement. In fact, we do not really have precise measures for either of these two positions, and they are difficult to develop. So, here too, once again, public policy, and treatment methods are based upon essentially untested hypotheses in conjunction with the personal proclivities of the policy makers.

As indicated earlier, many addicts had criminal records before addiction. Also, "From almost his earliest days, the addict has been systematically educated and trained into incompetence. Unlike others, therefore, he could not find a vocation, a career, a meaningful sustained activity around which he could ... wrap his life." (Chern, 1969:23) Therefore, individuals who become addicted in their early teens rarely have had an opportunity to develop attitudes and the work habits that are approved by society. As a result of this, it should be seen that some individuals from these groups would continue to engage in criminal activity even if heroin, suddenly, were distributed without cost or illegality. The amount of crime that supports the habit of today's addicted would diminish, but it would not be eliminated. We cannot, and do not know the extent to which crime would be diminished.

Even when this is understood by policy initiators, it is rarely mentioned by them in public discussion. This, in turn, feeds the false hopes and expectations that simplistic, punitive solutions that are in effect now will actually solve many of the problems of addiction related crime.

Another related factor which tends to escalate public concern and reaction are the estimates that often are given of the number of addicts, and the dollar costs of their thefts. There is no doubt that there are many addicts, and they do engage in extensive theft. However, these estimates often are overstated, and sometimes wildly so. One writer on drugs may quote another as his source of factual information, and that writer may have obtained his information, similarly, from a third. Max Singer (1971:3) in a brilliant article in The Public Interest, demonstrated the weaknesses of these estimates that are used widely. "It is generally assumed that heroin addicts in New York City steal some two to five billion dollars worth of property a year, and commit approximately half of all the property crimes. ... The estimate that half the property crimes are committed by addicts was originally attributed to a police official and has been used so often that it is now part of common wisdom." If one assumes that there are 100,000 addicts, with a \$30 habit, and assuming that the stolen property is sold only for a quarter of its value, addicts then must steal between \$4 and \$5 billion a year to pay for their heroin. Singer demonstrates that a quarter billion dollars a year is a better estimate, though perhaps on the high side. One quarter billion dollars in property theft is a great deal of money -- probably more than we spend on rehabilitation, and other programs to prevent and control addiction. It is, however, ten times smaller than the figure usually used and accepted.

The estimate of the numbers of addicts also may be derived from different sources of information and this may lead to wide variability

in the reporting. The Bureau of Narcotics and Dangerous Drugs of the U. S. Justice Department indicated that there were less than 70,000 active addicts in the United States in December, 1969 (U.S. Department of Commerce, 1971:79), but almost 95,000 unduplicated names of narcotics abusers were reported to the New York City Narcotics register as of that date. (Brodney, 1971:4) The greatest difficulty, however, is in estimating the number of addicts who may not be known by official agencies. "It has been suggested by many experts in the field of drug abuse that for every narcotics addict known to authorities, there is at least one unknown to them." (Lavenbar, 1973:807) Lavenbar comments that attempts to estimate the number of heroin users have led to what he calls the extrapolation game. If followed to its logical end, as he demonstrates, it can indeed lead to highly overstated figures.

This game was originated in New York City where all deaths suspected of being attributed directly or indirectly to heroin are carefully investigated by the office of the Chief Medical Examiner. It was discovered that only one-half of the 900 persons with heroin-related deaths in 1968 were listed in the city's narcotic register. Therefore, assuming that heroin deaths are distributed randomly among all users, it then follows that the 52,000 registered users represent only 50 percent of the actual total. Therefore, it was estimated that there were approximately 104,000 heroin users in New York City in 1968. Since it is suspected that the nationwide total is approximately twice that of New York City, the total number of heroin users in the United States was estimated to be in excess of 200,000. In recent years, however, it has been observed that almost two-thirds of all the heroin-related deaths were not previously known to the register. Can we now assume that the 165,000 plus narcotic users currently registered in New York City represent approximately one-third of the total number of users? At this rate our estimates of addiction soon exceed our population totals. (Lavenbar, 1973:808)

Singer comments that the most popular estimate of addicts in New York City is 100,000 plus, and the 200,000 figure is sometimes used. He points out that "... the number of addicts is basically --although imprecisely -- limited by the amount of theft" and it follows then that "... The amount of property stolen by addicts suggests that the number of New York City street addicts may be more like 70,000 (in 1971) than 100,000 and almost certainly cannot be anything like the 200,000 number that is sometimes used. Several other simple ways of estimating the number of street addicts lead to a similar conclusion." (Singer, 1971:3)

The tragedy involved for 70,000 is great, both for individuals and their families. However, as with property theft estimates, the widely

accepted figures, are overstated. This overstatement feeds the myth of addiction out of control, which in turn, in our society leads to more punitive solutions. The numbers game is a debilitating factor in attempts to develop rational planning and social policy.

One would hope that research efforts would lead to policy initiatives based on hard, factual knowledge. However, research into the broader arenas of causes of addiction, as well as the personality structure of the addict have not been conclusive. One review of the literature, in pointing this out, had this to say:

While there seems to be agreement on the general point that adolescent users are usually subject to deficient parental models, there is marked disagreement as to the nature of this deficiency. One or both of the parents are characterized as being either overprotecting, overdominating, underdominating, or rejecting. This lack of consensus can be attributed to the heavy reliance on retrospective studies of the narcotic users' parents. (Braucht et al, 1973:97)

Braucht et al further indicated that although addicts have been found to be immature, insecure and irresponsible, the way in which all of these traits fit together is unclear. This is a result of lack of sound theoretical structure as the point of origin for these studies. Furthermore, there is hardly any agreement whatsoever about the dynamics of the personality disorder of the addict. In addition, "The use of controlled convict and clinic populations in this body of research casts considerable doubt on the validity, reliability and representativeness of the research findings." (Braucht et al, 1973:87) Other literature reviews have commented similarly.

This is important to note, as one of the most frequently heard comments in drug discussions is the plea for more research before implementing new policies. Indeed, "... the idea persists that somehow 'research'-- if only we had enough of it--will convert difficult policy issues into hard certainties. Its corollary is caution: any permissiveness towards drug users is premature ... rather than risk engraining a possibly harmful practice, a hard line approach should be kept until all the answers are in." (Zinberg & Robertson, 1972:87) As it relates to public drug policy, it is reasonable to assume that the call for more "research ... can serve as a transparent dodge for the postponement of action ..." (Rein, 1970:204)

Basic drug research is needed urgently in a wide variety of areas. However, it will not aid us with the central issues of social control,

nor will it be of substantial help with the fear and irrationality of our reactions, responses and feelings regarding the drugs we consider unacceptable. Research cannot answer the questions about whether personal use and/or possession of a drug should be criminal. This remains a question answered by our value system, and essentially the answer continues to be a punitive one.

If one used logic in formulating policy regarding heroin, it would hold that we might move to either the law enforcement or medical approaches depending on the greater success of one approach as opposed to the other. "Success might be measured in terms of an approach which leads to a decrease in the crime which is a tangible cost of addiction, and in the number of individuals who, as a result of the approach abstain from heroin use. Using these indices as a measure, neither approach can be called successful ... The law enforcement approach has not stopped the movement of drugs in this country. It has been largely unsuccessful in deterrence of heroin and in efforts to rehabilitate users ... law enforcement can raise the price of heroin although it cannot stop its distribution." (Salmon, 1976:185-186) Furthermore, there is reasonably wide agreement that therapeutic interventions, including methadone maintenance cannot lay claim to statistically significant levels of success in either reducing crime, or in eliminating drug dependence (National Commission on Marijuana and Drug Abuse, 1973:177). Methadone, which had been viewed as the latest panacea for the problem has not lived up to its expectations. (New York Times, May 11, 1976:11). Kleinman and Lukoff (1977:209), in impeccable research determined that one large not-for-profit methadone maintenance program in New York City, for five years, was not effective as an agent of change. Furthermore, their reanalysis of most methadone program reveals them as considerably less successful than initially suggested.

As a result of these unimpressive results of current treatment modalities, we have seen a resurgence of suggestions for the consideration, or reconsideration of heroin maintenance in this country. "The central point is that only a small population of heroin addicts will voluntarily seek out and remain in any form of treatment, care, or confinement -- unless that care involves the predisposition of heroin itself." (Wilson et al, 1972:20) These suggestions have been made by, among others, a grand jury in San Diego, California, The National League of Cities, and the Massachusetts Council of Churches (Fritchey, November 6, 1976:27), Edward Brecher and Consumers Union (1972), the Canadian Commission of Inquiry into the Non-Medical Use of Drugs (1972), Lidz (1975) and various journalists and political figures. Also, as reported in The United States Journal of Drug and Alcohol Dependence (September, 1977:1) "There is demand in the drug

rehabilitation community for a heroin maintenance experiment. One argument is that all else seems to have failed -- so what is there to lose."

In the United States, where policy has been formulated on a conception of the addict as one who uses narcotics for pleasure, one rationale for heroin maintenance may be based on the frustration with the failure of current containment methods. In Great Britain, however, heroin policy has been based on a different conception of the addict. British policy makers believe that most individuals became addicted as a result of medical treatment (Schur, 1962) and heroin maintenance was seen as more appropriate and acceptable. This form of care has been a possibility in Great Britain since 1926 when the Rolleston Committee defined addiction, and suggested a policy for the treatment of addiction. It said, an addict is "... a person who, not requiring the continued use of a drug for the relief of symptoms of organic disease, has acquired, as a result of repeated administration, an overpowering desire for its continuance, and in whom withdrawal of the drug leads to definite symptoms of mental or physical distress or disorder." (Judson, September 24, 1973:93) The Rolleston report, remarkably, was the basis for public policy for forty-two years.

In 1960, however, England started a decade of spiraling narcotics addiction. The British narcotics problem was minor compared to the United States, never counting more than 3,000 registered addicts. (The Drug Abuse Survey Project, 1972:345) but it was cause for concern. In 1968, the British government, acting on the assumption that irresponsible prescribing had caused the increase in addiction, set up a series of clinics, and restricted the right to prescribe heroin to physicians associated with those clinics. "The population of known addicts stopped growing almost immediately under this new policy, with both new cases and total cases decreasing." (Lidz et al, 1975:39)

As they evolved, some 27 clinics opened. These clinics varied, and continue to vary, tremendously. A psychiatrist must be in charge, and all clinics have at least one nurse. Some clinics include social workers on the staff while others do not. There is a great range of programs, and patterns of service in these special clinics. It is hardly accidental, as the British have a belief in individual medical autonomy that exceeds ours considerably. There is considerable consistency in one area, however. Addicts usually do not receive drugs from clinic staffs. Instead, a prescription is mailed to a pharmacy, and the addict obtains his drug there. He picks it up daily, except over the weekend, when he is given a two-day supply. The prescription usually is for a week's supply. It should be recognized that "the prescription is what brings the addict to the clinic every

week; once he is there, what he talks about with the psychiatrist and the social worker ... will be his job, housing, his parents, his girlfriend -- ordinary things -- and drugs in relation to these." (Judson, October 1, 1973:92)

What everybody knows about the clinic system is that heroin may be available on prescription to addicts. The frequent assumption that is the partner to this knowledge is that there is easy access to narcotics, and that one may become registered easily as an addict, and therefore receive cheap, safe, and legal drugs. This, however, is not so. In fact, "... clinic physicians have become extremely wary of new applicants claiming addiction, and the physician may require ... a series of tests or a period of hospital evaluations ... the burden of proof is always on the alleged addict." Furthermore, "... the assumption that all addicts rush to the clinics to be registered is faulty." (Weisman, 1972:63)

Once an addict is registered, there is no automatic guarantee that heroin will be prescribed. In fact, there has been a consistent reduction in the number of heroin prescriptions written at the British clinics, and an increase in the number of methadone prescriptions provided. (Johnson, 1977) In 1977, "The number of officially registered addicts in Britain has declined somewhat, with about 90 receiving free heroin and about 1,300 obtaining methadone from the Health Services' drug clinics." (New York Times, February 2, 1977:A6) As restrictive practices by the clinics were introduced:

...this has increased the supplementation that is done by the clinic addicts and has provided the basis for a black market in imported "Chinese" heroin for clinic addicts. Both clinic and street addicts have shifted rapidly from taking only heroin to taking a mixture of heroin and methadone and many are now taking only methadone. Only a very small number of new heroin addicts have been showing up at the clinics, although increasing numbers of methadone addicts have been applying for treatment. (Lidz et al, 1975:39)

Another fact that should be considered is that in the years that the clinics have operated there has been a change in the goals of the clinic staff:

The doctors have quietly refused to remain mere agents of social control. Though they acknowledge that there are addicts whose addiction can only be supported, the clinic staffs have gradually come to have a commitment to the eventual integration of the addict into the community, and to the gradual diminution of doses. In this fundamental respect, the English approach to heroin maintenance is the reverse of the surrender that many Americans take it to be. (Judson, October 1, 1973:11)

If this is so, what success or failure has been achieved by the British system? It does seem that the British system as it is constituted has an effect on limiting the availability of narcotics. In 1970, only two years after the British moved to its clinic system, there was a decrease in registered addicts. The amount of heroin prescribed in the clinics has declined. Methadone prescriptions, which are rising, are slowly replacing heroin. However, there are fewer newcomers addicted to anything as compared to previous years. (The Drug Abuse Survey Project, 1972:346-347)

There are very few people who correlate drug addiction and the rising crime rate in Britain. We, in the United States, feel that addiction to heroin turns the individual into a person who cannot work, but this view is not held universally in England. Addicts work regularly and the estimates of employed addicts go as high as 50 percent (The Drug Abuse Survey Project, 1972:347-348). There is speculation that the British way of stabilizing and reducing a patient's dosage of a drug such as heroin which normally develops tolerance and requires increased dosage may be possible because the clinics supply a regular contact with a supportive and concerned psychiatrist. Perhaps "... the major achievement of the British approach has been the definition of the addict as a patient, and not a pariah." (Weisman, 1972:65) This allowed most of the English addicted to receive health services in clinics where they get adequate medical care and "pure" drugs, without the necessity of resorting to criminality to pay for their habits. They receive this care until they are ready for other forms of treatment to reduce or eliminate drug intake. This medical approach, which is benign and humane, may in and of itself lead to a decrease in narcotics use in England.

The policy makers in the United States repeatedly have rejected the idea that the British system could have applicability here. The huge differences in the social classes of the English and American addict, the differing social climates in the two countries, different traditions as well as laws have been offered as some of the reasons that the British system could not be applied here.

However, a young Canadian sociologist, Jim Zacune, in 1969 started to trace the ninety-one Canadian addicts who were known to have come to Great Britain in the 1960's. His study was of importance as Canada patterned her drug policies after that of the United States, and it could shed some light on the applicability of the British plan with non-English individuals.

He located twenty-five Canadian addicts who still were in England, and they were, certainly, a biased sample. They were older than the English addicts, and were taking higher dosages than their English

counterparts. Other questions about the design of the study could be raised. Despite this, a comparison of their work, crime, and prison records in the two countries was of extraordinary interest. In England, thirteen of the twenty-five were employed full time, for periods of time from six months to seven years. Others worked part time.

In Canada, the addicts had been convicted a total of one hundred and eighty-two times, and they spent almost one year out of four, after becoming addicted, in prison in Canada. After emigrating to England, they compiled twenty-seven offenses, and though six of them did some time there, the combined total was two years and five months -- or less than one year out of 50 years combined they had lived in England. (Judson, September 24, 1973: 108) The results of this study, as limited as they may be, are important. It indicated with clarity the distinct advantages for the addict who lives in a nation where addiction is not criminal. It also indicates that despite the difference in our societies we cannot rule out the possibility of heroin maintenance as one of the treatment modalities for this country. Recognizing this possibility for the future, the National Commission on Marijuana and Drug Abuse, in considering heroin maintenance cautiously said, "...As in all matters relating to drug policy, this alternative should not be permanently foreclosed." (National Commission on Marijuana and Drug Abuse, 1973:337)

Our law enforcement policy towards our addicts has tended to produce alienated and intractable addicts, and yet our policy makers continue this kind of policy. It is odd indeed that the American model bases its intent on a medical absolute, the seeming truth that cure should be the object which means getting the addict off heroin -- while the British have supposed that the treatment of the addict, though exclusively the responsibility of the doctors, should be predicated on a realistic view of what can and what cannot be enforced.

The American policy goal has been to suppress the problem rather than to deal with the cause. Methadone Maintenance had great support from agencies, political figures, etc. because of its potential for reducing crime, and it is seen by many as a law enforcement strategy. Indeed, many features of the present response reflect the fact that our therapeutic approach to drug use and dependence remains a step-child of the criminal process. The helping professions are involved as agents of social control in relation to addicts, despite discomfort with this role.

Social work is one of the fields of human service that pays dearly for this dilemma. Social workers staff the clinics, institutions and agencies that carry out our punitive drug policies. Social control

is one important objective of these policies. As a result, the social work professional must deal each day with his own continuing conflict with his belief in his client's right to self-determination, and choice, and the role he is paid to perform with these clients.

The introduction of carefully conceived heroin maintenance programs could, in time, serve to change the prevailing social atmosphere for the addicted client, as well as for those who would help him. The physicians could assume their traditional role concerned with those functions specific to restoring persons to a state of physical or mental health. Social workers, along with other helping professionals, could concern themselves, and work with the addict toward the alleviation of life problems that his client feels are important. This would free the social worker, as well as other professionals, to work in the manner for which they have been trained. A change such as this would benefit both the addicted and his helpers.

It is not suggested here that the introduction of heroin maintenance would solve the problem of heroin addiction. Indeed, as the author has stated elsewhere, it has:

...become apparent that heroin addiction is one of those conditions or illnesses in which there are many serious gaps in knowledge, and that there are no ready answers provided by the current theories of addiction. We need to face the fact that at this time there may be no totally appropriate intervention for most or for some of the unfortunate individuals addicted to heroin. (Salmon and Salmon, 1977:949)

For this reason, in particular, no possible source of help should be foreclosed, as we have done. The British example shows how far we have to go, and in a sense, how primitive we have been. The British tend to view the addict as ill, rather than evil. It is to be hoped that our beliefs and actions will shift in that direction.

When this occurs, and it may in time, we may see increased experimental use of heroin maintenance under controlled conditions, and hopefully a change in our attitudes toward illness and social problems that will allow both addicts and non-addicted to live with more dignity and security.

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