

# Appendix A: Drug Control Policy in the United States: Historical Perspectives

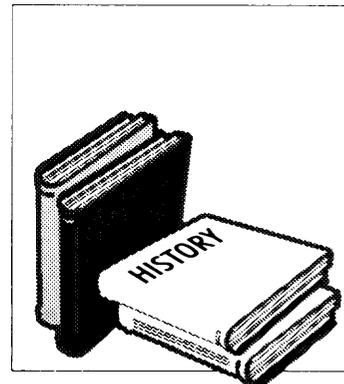
# A

**T**he United States has always been a drug-using country. In colonial days, people drank more alcohol than they do today, with estimates ranging from three to as many as seven times more alcohol per year (13). While public drunkenness was a criminal offense, it was generally considered a personal indiscretion. (1). The temperance movement began in earnest after the Revolution, when heavy drinking was revealed to be a problem, and religious figures became committed to temperance. (1). Since then, the American experience with both licit and illicit drugs can be viewed as a series of reactions to the public's shifting tolerance toward their use (9).

## THE EARLY 1900s: NARCOTICS AND COCAINE

In the late 19th century it was possible to buy, in a store or through mail order, many pseudomedical preparations, containing morphine, cocaine, and even heroin (9). The ubiquitous soft drink Coca-Cola used to contain cocaine until 1903, when it was replaced with caffeine (9). Pharmacies sold cocaine in pure form, as well as a number of opium-derived drugs, such as morphine and heroin, the latter of which became well-known when it was marketed by the Bayer Co. beginning in 1898 (10). Physician prescriptions of these drugs increased from 1 percent of all prescriptions in 1874 to between 20 to 25 percent in 1902; they were not only available but they were widely used, without major concerns about negative health consequences (14).

Cocaine and narcotic preparations were taken off the market for various reasons. Increasing awareness of the hazards of drug use and adulterated food led to such regulations as the Pure Food and Drug Act of 1906 that required that fraudulent claims be removed from patent medicines, as well as disclosure of habit-



## 178 | Technologies for Understanding and Preventing Substance Abuse and Addiction

forming substances. The passage of several anti-narcotic and pharmaceutical labeling laws was spurred on by these health concerns, a growing temperance movement, the development of safe pain relievers (such as aspirin), a broader range of medical treatments, and the growing immigrant population thought to be associated with specific drug-using practices. However, these laws did not make patent remedies, cocaine, and opium illegal. Some individual states imposed tighter restrictions on their availability, but there was no uniformity among state laws. It was United States involvement with international narcotics concern that led there (9,10.1 4).

In 1909, the International Opium Commission called by the United States, met in Shanghai, to begin an international discussion concerning the problems of narcotics and the narcotics trade. Twelve nations, in addition to the United States, were present to discuss problems relating to opium. At that time the perception in the United States was that Chinese immigrants were to blame for the opium smoking problems. This angered the Chinese, who had instituted strict campaigns against the sale and use of opium within their own country. The Chinese were seeking U.S. assurances for help in ending Western opium trafficking into China. The State Department not only wanted to support China drug control efforts, but thought that international drug control measures would help stanch the flow of drugs into the United States, and thus the nonmedical consumption of these drugs. It would not be until two years later, in the Hague, that a treaty would be signed stating that all the signatories would enact domestic legislation controlling narcotics trade, specifically limiting the use of narcotics for medicinal purposes (9,10).

Hamilton Wright, the State Department's opium commissioner, attempted to draft legislation but met opposition from the States, the medical profession, pharmacists and pharmaceutical companies. After nearly three years of debate, Congress passed the Harrison Act in December 1914 (named for Representative Francis Burton Harrison, who introduced the initial form of the bill for the Administration). The bill provided for strict

control of opium and coca and their derivatives: both their entry into the country and their dispersion to patients. Maintenance of addicts by physicians was allowed until 1919. Opposition to the Harrison Act came mainly from pharmaceutical companies and pharmacists, who objected to what they called the Act's confusing and complex record keeping requirements (9).

Passage of the Harrison Act reflected, in part, growing public sentiment that opium and cocaine were medicines to be taken only in times of illness (and then only when prescribed by a physician) and that these substances could cause insanity and crime, particularly in foreigners and minorities. Smoking opium was associated with Chinese immigrants; popular belief also held that cocaine would affect blacks more forcefully than whites and incite them to violence. Marijuana was believed to have been brought into the country and promoted by Mexican immigrants and then picked up by black jazz musicians. These beliefs played a part in the 1937 Marijuana Tax Act, which attempted to control the drug's use (9). As early as 1910, many people argued against any nonmedical use of narcotics.

## PROHIBITION AND BEYOND

### ■ Focus on Alcohol

Ratification in 1919 of the 18th amendment prohibited the manufacture, sale, transportation, importation, and exportation of alcohol and shifted the Nation focus for more than a decade from the dangers of narcotics to the Nation's alcohol problems. Prohibition had its roots in the Temperance Movement, which began shortly after the Revolution. In 1784, Benjamin Rush, a physician and signer of the Declaration of Independence, published a pamphlet entitled, "An Inquiry Into the Effects of Ardent Spirits on the Mind and Body," which was widely disseminated among Temperance leaders. In it he described a "disease model" of excessive drinking, which characterized drunkenness and alcohol addiction as a "disease of the will," in addition to causing many physical diseases. By the mid-19th century, the American middle class had become more aware of the dan-

gers of alcohol to the family, the nation, and the factory (1). By the late 19th century and early 20th century, the Temperance Movement came to be associated almost exclusively with American Protestantism as a political mechanism to control the growing numbers of non-Protestant immigrants. This political and social strength helped, in 1919, to ratify the 18th amendment which forbade the sale of alcoholic beverages, and to implement it by means of the Volstead Act in 1920 (1).

The shifting tolerance of Americans toward substance use is evidenced by the successes and failures of the Prohibition era. In 1919, many were optimistic that the prohibition of alcohol would solve many of the country's social problems. If alcohol contributed to the crime and unemployment associated with the cities, then removing it from the market might help solve those problems. However, despite evidence that consumption declined (based on declining rates of death due to cirrhosis and of alcoholic psychosis in State mental hospitals), there is also evidence that widespread dishonesty existed in the enforcement of dry laws. Jobs to enforce Prohibition were doled out as political favors, which may have contributed to graft, corruption, and the surge in underworld crime (9, 17). In addition to the perceived rise in corruption, the passage of progressively stricter laws regarding violations of the Volstead Act also contributed to waning public support of prohibition (17). The 1933 repeal of Prohibition signaled that public sentiment had once again become favorable toward alcohol, and alcohol and its related problems returned to private, rather than public, arenas.

The scientific literature of the 1930s and early 1940s concentrated mainly on captive alcoholic populations in jails, mental hospitals, and skid row, allowing many Americans to distance themselves from alcoholism (1). During this same period, Alcoholics Anonymous (AA) was founded, but lacked mainstream recognition until the 1950s and 1960s when the scientists lent support to the disease model of alcoholism, which has always been the central tenet of AA (1, 11).

### ■ Focus on Narcotics

While alcohol experienced a transition period in respect to public tolerance, negative attitudes toward narcotics and other drugs remained constant, or became even more severe. During the 1920s, the Federal government expanded its antidrug efforts through new Treasury Department regulations (8). In 1930, President Hoover created the Federal Bureau of Narcotics and appointed Harry Anslinger as the Commissioner of Narcotics. A position Anslinger held from 1930 to 1962, a precursor, perhaps, to the modern day drug czar. For more than three decades, Anslinger oversaw all aspects of drug control, from interdiction to domestic supply, to public relations. He effectively used religious and other antidrug groups to maintain a high antidrug sentiment in the country. He also controlled the flow of legal drug supplies, by keeping watch over doctors who might prescribe unusually large amounts of narcotics. Anslinger was opposed to the medical treatment of addiction, and addicts, like alcoholics, were seen as deviants (9, 15).

Prior to the mid-1960s, marijuana use in the United States was mostly confined to various subgroups such as Mexican laborers, jazz musicians, and beatniks. Although portrayed as a killer weed and a menace by anti marijuana reformers, there is little evidence that it was either at this time. In 1937, the Marihuana Tax Act (the Federal government then spelled marijuana with an "h"), became law, making the use and sale of marijuana without a tax stamp Federal offenses. Some companies were permitted to apply for a license to use cannabis products (e.g., for birdseed, paint and rope), and doctors could still prescribe marijuana in limited circumstances. However, starting in 1937, recreational use was punished with greater severity (15). Some speculated that the passage of the Marihuana Tax Act resulted from strong anti-Mexican sentiment in the Southwest and the political power of Anslinger (5).

Intolerance toward drug use was very strong in the 1930s and 40s. Federal laws concerning the

sale and use of drugs got progressively stricter, culminating in the introduction of the death penalty for the sale of heroin to anyone under 18 years old by anyone older than 18 (10). Illicit drug use during these decades was low in the mainstream population. This marginalization of narcotics (or at least, of the people who used them) may have played apart in the resurfacing of these drugs after the 1930s. There was a concern during World War II that American soldiers in Asia would succumb to drug supplies available in those countries and return home with drug habits. The Bureau of Narcotics received no budget increases, since Congress apparently believed it was well equipped to deal with the current drug levels (9).

In the 1950s, however, heroin was brought into the country in larger quantities than at any time since it was outlawed. Dealers learned that poor quality heroin could be sold at inflated prices, and this higher cost pushed users into criminal lifestyles heretofore not seen on such a wide scale (12). A nationwide scare that drug use would spread from the urban poor (mostly minorities) to the rest of the country erupted. The fact that young people appeared to be the biggest users of heroin was particularly alarming. This fear was reflected in the passage of the Narcotic Control Act of 1956, which increased penalties for the sale and possession of marijuana and heroin (15).

The reaction to this rise in drug use was not entirely fearful, however. Scientific and technological advances offered alternative answers to coping with the drug problem a switch from the past tactics of law enforcement. Even though the stereotypical heroin user was still a poor minority, new ideas for treating and helping these people emerged as part of increasing acceptance of the medical model of addiction. In the 1960s, methadone maintenance pilot programs were launched. By using the long-acting opioid methadone for treatment of addiction to the short-acting opiate heroin, these programs offer a way for heroin addicts to control their addiction (6).

## 1960s-PRESENT

In the 1960s, white middle-class youths, who were more visible than their minority counterparts, began experimenting with drugs, including marijuana and heroin, causing wide public concern and demand for more treatment approaches and additional law enforcement (17). Some of this new interest in drug use may be attributed to the intolerance toward it in the preceding decades. Marijuana had never been widely used, and after the 1930s its use was not a widespread concern. It was rediscovered by young people in the 1960s, who had grown up with parents who used alcohol. Some of the drug consumption may also be linked to an increase in consumption generally during the late 1960s and early 1970s, the Vietnam War protest movement, and the rapid changes in American society that occurred in those years (9,10,17).

Despite the image of the sixties as a time of widespread experimentation, the increase of drug use activated many who had been quiet on the issue. Marijuana, the drug of choice among many young people, was seen by some researchers as the gateway to more dangerous drug use. Richard Nixon was elected President in 1968 on a law and order platform, and it is said that no other President has campaigned as hard against drug abuse (9). As during World War II, concern rose that soldiers serving in Southeast Asia would develop drug habits while there. In this case, the fears were well-founded, as many servicemen did avail themselves of cheap supplies of heroin and marijuana. However, even among those who became addicted, many stopped their drug use upon returning to the United States. During the 1960s, the old linkages between corruption, Asians, and opium surfaced once again in public opinion, leading to more stringent measures to stop the flow of drugs into the United States from both Asia and Latin America (8).

Public support of law enforcement against drugs was high during the late 1960s and early 1970s, and President Nixon spoke of mounting “a frontal assault on our number one public enemy [drugs],” but long mandatory minimum sentences for possession of small amounts of marijuana dis-

turbed many Americans, even those who did not approve of marijuana use. The Comprehensive Drug Abuse Prevention and Control Act of 1970 lessened penalties for possession of marijuana. It also established a system for classifying drugs into five schedules, which is still used today. Drugs are placed in each schedule based on their potential for abuse, their known harmfulness, and medical value. Marijuana and heroin are listed in schedule 1-drugs with high potential for addiction and no recognized medical value. There have been, however, limited experimental programs approved by the DEA and FDA for the use of marijuana in treatment of nausea due to chemotherapy and of ocular pressure due to glaucoma. Cocaine is listed in schedule 2-drugs with potential for addiction for acceptable for some medical applications. Subsequent to the establishment of this system, drug policies and laws for individual drugs have been based on the drug's schedule (3,16).

In 1972, the President's National Commission on Marijuana and Drug Abuse recommended that the laws against the use of marijuana be relaxed, since the enforcement of these laws was becoming too burdensome to police in some areas, and was considered intrusive on individual privacy in others. The drug was increasingly thought to be innocuous in its effects, both by scientists and others (4). Several States passed decriminalization laws, which allowed possession or use of small amounts of marijuana and imposed fines instead of prison sentences for transgressions of minor possession laws (10). The Commission remained strict on cocaine, which was also seeing a surge in use, but few experts thought it was physically addictive or should be classified in the same category as other narcotics.

Despite President Nixon's emphasis on "law and order" responses to drug use, his drug budget favored prevention, education, and treatment. The National Institute on Drug Abuse (NIDA) was created as the lead agency for demand reduction, directing Federal prevention and treatment services and research. The Drug Enforcement Administration was created as the lead agency for supply reduction, and single state agencies were

created to guide Federal funds into state and local antidrug programs (3).

From the mid-sixties to the late seventies, the composition of drug users changed substantially. While drug use was still associated primarily with minorities and the lower classes, drug use by middle-class whites became a widespread and more accepted phenomenon. As in the late nineteenth and early twentieth centuries, when middle class whites haphazardly used narcotic preparations, this new group of drug users down-played or ignored the dangerous effects of drugs, and extolled their virtues as agents of nonconformity and mind-expansion. Cocaine was an expensive and high-status drug, used mainly for recreation by upper- and middle-class whites.

From the drug experiences of this cohort, which were by no means entirely positive, the public of the late seventies was better educated about the effects of drugs, and public disapproval of drug use began once again to increase. Drug use, however, particularly of cocaine and marijuana remained high. The Ford Administration (1974- 1977) focused on the drugs it thought posed the greatest danger—heroin, amphetamines, and barbiturates. Some even thought that drugs such as cocaine and marijuana should be legalized, "so as to end the enormous government expenditures of money and time on a problem that only seemed to bring profits to drug dealers and elicit contempt for the law from an ever-growing body of drug users" (9).

During the Carter Administration (1977-1981), Peter Bourne, a special assistant for health issues, argued for Federal decriminalization of possession of small amounts of marijuana, while focusing interdiction efforts on heroin. But Bourne resigned over a scandal involving criticisms over his prescribing practices. His resignation forced President Carter to take a harder position on drugs, and Federal decriminalization never occurred. There were still States in which marijuana was decriminalized, but these decreased in numbers through 1990, when the last State—Alaska—to have decriminalization repealed those laws.

The departure of Bourne coincided with the emergence of several parents' groups concerned about drug use by their preteen children. One group in particular, in Atlanta, Georgia, became enraged when they found that in addition to drug use at parties, their children were able to buy drug paraphernalia and prodrug literature in local stores. The group formed the Parent Resources Institute on Drug Education, National Families in Action, and the National Federation of Parents. These groups were instrumental in prodding NIDA to publicize more widely the dangers of marijuana and other drugs once thought of as harmless.

The Administration of Ronald Reagan (1981-1989) favored a strict approach to drug use and increased law enforcement. First Lady Nancy Reagan actively campaigned against drug use, urging school children to "Just Say No." At the same time, funding for research and treatment decreased, while the availability of cocaine, heroin, and marijuana remained the same (9). The budget for antidrug related activities rose from \$1.5 billion in 1981 (split nearly equally between supply reduction (domestic law enforcement and international/border law enforcement) and demand reduction (research, prevention and treatment) to \$4.2 billion by the end of President Reagan's second term. Two-thirds of the funds were now allocated for law enforcement activities, with the remaining third allocated for demand reduction (2). In 1984, the Crime Control Act increased dramatically Federal mandatory minimum sentencing provisions for drug-related crime, including the manufacture, distribution, or possession of controlled substances. It also expanded the criminal and civil asset forfeiture laws to penalize drug traffickers and increased Federal criminal penalties for drug-related offenses (3). This trend continued through the remainder of the Reagan administration as well as that of President Bush.

The 1980s saw significant shifts in patterns of cocaine use. The negative effects of cocaine use, especially long-term use, had previously been masked, but middle-class users with drug-related problems suddenly were more common. Concurrently, cocaine smuggling escalated, resulting in

increased availability, lower prices, and higher quality. Low-income, minority communities began experiencing major drug problems, first with powdered cocaine, then in the mid-eighties especially with the new form of cocaine-crack. Commonly called an epidemic, the spread of this smokable cocaine inspired both President Reagan and antidrug groups to heightened drug intervention efforts. Crack appeared to be highly addictive, as well as affordable, and fear of its consequences forced many lawmakers into action. The Anti-Drug Abuse Act of 1986 authorized more funds than ever before for the war on drugs, most of which was designated for international interdiction activities (9), and the establishment of the Office of Substance Abuse Prevention (OSAP). The AIDS epidemic has also affected patterns of drug use, since some intravenous (IV) drug users may have switched to smoking crack in order to avoid exposure to the AIDS virus. Other IV drug users, however, have continued to inject, and comprise a large percentage of the AIDS-infected population.

While the main focus of drug control policy in the 1980s was interdiction of illicit drugs, significant policy initiatives concerning alcohol were also implemented. For example, the goal of the national minimum drinking age of 21 was stated in 1984 and achieved by 1988. Warning labels were required on all retail containers of alcoholic beverages beginning in 1989 (7).

When George Bush was elected President in 1988 the climate within the country was highly intolerant to the use of illicit drugs. President Bush echoed President Nixon when he declared that the drug epidemic was "public enemy number one" (16). The Anti-Drug Abuse Act of 1988 mandated the creation of the Office of National Drug Control Policy (ONDCP), to be headed by a director, sometimes called the drug czar, who would coordinate U.S. drug control and abuse policy, resources, and operations (Public Law 100-690). The first director was William Bennett, former Secretary for Education under President Reagan. He was followed by Robert Martinez, former Governor of Florida. The director, in conjunction with the President and Cabinet Secretaries, sets

## Appendix A Drug Control Policy in the United States: Historical Perspectives I 183

Administration policy on drug control. However, ONCDP lacks budgetary authority, and under President Bush the director of ONDCP was not a Cabinet position. During the Bush Administration, additional funds were authorized for the war on drugs, including increased funds for treatment and prevention. However, most of the funds were designated for law enforcement activities. Spending for antidrug-related activities rose from the high of \$4.2 billion under President Reagan, to a proposed \$12.7 billion in the last year of President Bush's term. Again, the monetary split was roughly two-thirds for law enforcement and internatio-

nal interdiction activities and one-third for demand reduction (2).

While "The War on Drugs" has remained part of the political lexicon, President Clinton, after taking office in 1993, cut the Office of National Drug Control Policy from 146 positions to 25. He elevated the director of ONDCP to cabinet status, and Lee P. Brown, former Police Commissioner of New York City was appointed to this position. During his campaign for the presidency, Clinton advocated drug treatment on demand, and the addition of 100,000 new police officers to the streets.