Well Researched, Factual Information About Drugs

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Drug Use and Anti-Drug Legislation

Every society has its own constellation of drugs and medicines and has a well-defined, if frequently shifting, line separating those which are acceptable and those which are not. And furthermore, every society must determine how it will treat users of unapproved drugs. Society's response to a drug user rests as much on social custom and historical events as on what is known about a drug's intrinsic pharmacological effects. Thus hot chocolate is acceptable as a children's drink even though it contains caffeine, a psychoactive drug which, on the other hand, makes coffee inappropriate for children. More significantly, these same customs and events affect the user's subjective reaction to the drug.

The social, economic or racial characteristics of identified users may influence how they are treated and how society reacts to the drug(s) they use. Dangerous drugs such as alcohol may come to be seen as harmless after years of continuous use or advertising, while relatively harmless substances may be thought of as, and eventually become, dangerous due to punitive legislation and "authoritative" propaganda. An example of such authority may be seen in the following descriptions, made in the early 1900's, when a different set of expectations prevailed:

> *The sufferer is tremulous, and loses his self-command; he is subject to fits of agitation and depression, he loses color and has a haggard appearance. The appetite falls off, and symptoms of gastric catarrh may be manifested. The heart also suffers; it palpitates, or it intermits. As with other such agents, a renewed dose of the poison gives relief, but at the cost of future misery.*
>
> (T.C. Allbutt and W.E. Dixon, *A System of Medicine*, Vol. II, Pt. I, p. 986, 1909)

> *(the drug) - is used – not as an idle or vicious indulgence, but as a reasonable aid in the work of life. The patient (consumed the drug) every morning and every evening for the last fifteen years of a long, laborious, and distinguished career. He persisted in this habit as being one which gave him no conscious gratification or diversion, but which toned and strengthened him for his deliberations and engagements.*
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> (ibid., p. 987)

The first is a description of coffee-drinking, the second of opium use. It is, then, important to assess both the biological *and* social effects of drug use. Policies based solely on clinical studies seldom take into account the drug effects which are expressed as social actions and responses. In addition, policies must strive to be practical as well as effective; past attempts to deal with illicit drug use have not always achieved this balance, sometimes creating unforseen, additional problems.

The period between the middle of the nineteenth century and World War I was the gestation period of U.S. federal drug laws. Around 1860 non-medical opium use, long a social pasttime in the Orient, was introduced into American culture by Chinese railroad laborers. For the next 50 years, opium was readily available in over-the-counter patent medicines and the casual use of morphine as a pain killer (popularized during the Civil War) was widespread. For many years opium use was not regarded as a menace to society and users participated in normal life. However, the proliferation of "opium dens" and their questionable habitués was disturbing to both the medical community and the government.

From the beginning Congress considered opium consumption in terms of crime and punishment rather than as a medical problem. Legislators attempted to prevent the "crime" of opium use by imposing economic regulations in the form of a tariff of $6/lb on imported opium. This was raised in 1883 to $10/lb and again in 1890 to $12/lb. Although revenues from this duty dropped off over the years, opium use remained prevalent. High government fees were accompanied by smuggling and the growth of a black market. The importation of opium in smoking form was completely prohibited in 1909 and with this, legal importation came to a halt, but the raw plant material still entered the country to be processed domestically. Then, in early 1914 a prohibitive tax of $300/lb was imposed on the processing of opium, so that the supply dropped sharply. As opium became increasingly difficult to obtain, users turned to morphine and heroin. These refined components of opium were more easily smuggled, but were, in addition, more hazardous.

In 1914 Congress also passed the first major anti-drug law, the *Harrison Narcotic Tax Act*. This legislation was justified as being necessary to the fulfillment of American obligations contracted at the Hague Convention of 1912, which included a resolution to curb widespread opium use in Asia. The Harrison Act was initially not intended to prohibit, but rather to regulate the distribution and use of narcotics. In keeping with precedent, the controls were economic, with the tax act to be administered by the Internal Revenue Service within the Treasury Department. The eventual consequence of the law was the replacement of legitimate sources of these drugs with underground supplies. Drug prices rose, creating the need for a large amount of money amongst a population of ad-

dicts, some of whom had no legal means of obtaining it.

Prohibitory interpretations which further aggravated this situation soon became apparent. The Harrison Act was enforced as a denial of the supply of narcotics to addicts. Addiction was not classified as a disease, and therefore could not be treated by a physician "in the course of his professional practice." Doctors who continued to supply narcotics could be convicted and imprisoned. In 1914 there were about one million habitual narcotics users in the country, many of whom had been maintained by doctors through legal prescription. When this source suddenly dried up the void was filled by an underground network of "dope-peddlers". Four years after passage of the Harrison Act, most major cities had reported a net increase in narcotic drug use, and in crime associated with it.

The response of Congress to this increasing drug use was to enact increasingly restrictive legislation. In 1919 an amendment explicitly prohibited the prescription of narcotics to addicts, and strongly curtailed over-the-counter availability of many drug preparations containing codeine. Users were more than ever at the mercy of black market connections, and left unprotected against adulteration and contamination of their drugs, as were alcohol users under Prohibition. With the *Narcotic Drug Import and Export Act* of 1922, Congress prohibited the importation of any opium product not required for medical practice and changed the maximum penalties from five years imprisonment to ten.

In 1930 Congress created the Bureau of Narcotics, recognizing that drug abuse was an increasingly widespread problem. Its new commissioner, Harry Anslinger, immediately sought to control the use of drugs not mentioned in the Harrison Act and which had recently entered the domain of popular use. Marijuana was an early target:

> *While opium can be a blessing or a curse depending on its use, marijuana is only and always a scourge which undermines its victims and degrades them mentally, morally, and physically. Medical experts agree on the complete unpredictability of the effect of marijuana on different individuals. A small dose taken by one subject may bring about intense intoxication, raving fits, criminal assaults. Another subject can consume large amounts without experiencing any reaction except stupefaction."*
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> (H.J. Anslinger, *The Traffic in Narcotics*, p. 168, 1953)

The *Marijuana Tax Act* was passed into law in 1937, bringing marijuana under stern controls similar to those regulating the opiates and cocaine. This was an economic measure designed to control by limiting all use specifically to the practice of medicine. However, an intensive propaganda effort aimed at discrediting the medical utility of marijuana and raising questions as to its safety caused the medical use of marijuana to virtually disappear. In the public mind, marijuana became a dangerous drug, and it joined heroin and cocaine as a target of increasingly strict penalties.

By the end of the 1940's official strategy in dealing with drug use was undergoing an explicit transformation from an emphasis on economic controls to punitive measures. In 1951 the *Boggs Act* established for the first time minimum penalties for all narcotic drug offenses and removed judicial discretion for second offenses. Whereas the *Uniform Anti-Narcotics Act* of 1932 had been designed to allow individual States to legislate their own narcotics laws, passage of the Boggs Act was followed by most states enacting "little Boggs Acts" which imposed penalties often far more stringent than those stated in the federal law. Moreover, many of these state laws defined addiction *per se* as a crime.

In 1956 the *Narcotic Drug Control Act* further increased penalties for illicit drug use and for the first time made a distinction between drug possession, drug sale, and drug sale to minors. It also established *mandatory* minimum penalties by eliminating suspended sentences, probation, and parole. Subsequently, the government also attempted to restrict the manufacture of synthetic narcotic drugs with the *Narcotic Manufacturing Act* of 1960. In 1962 the Supreme Court intervened in the tide of narcotic law-making and ruled that imprisonment merely for being an addict was cruel and unusual punishment; however, the related acts of purchase and possession remained punishable.

Over the years, drug technology has expanded, with a proliferation of many types of drugs for various purposes. Many drugs that are useful and acceptably safe under medical supervision have shown abuse potential within one or another American subculture. Sedatives, stimulants and tranquilizers were all developed for medical use, but are frequently used without medical supervision. To deal with these numerous unsanctioned uses, Congress enacted the *Drug Abuse Control Amendments* in 1965, extending drug laws to include these psychotropic drugs and, later, in 1966, hallucinogens such as LSD, mescaline, peyote and psilocybin.

Along with the elaboration of the drug laws themselves has come a series of reorganizations of the enforcement agencies charged with administering the law. In 1966 the Bureau of Drug Abuse Control was established, under the aegis of the FDA, to enforce laws pertaining to these amendments. This left the Bureau of Narcotics (Treasury Department) with the responsibility of enforcing the "hard" narcotics and marijuana laws. Two years later these two often-conflicting bureaus were combined into a single administrative body, the Bureau of Narcotics and Dangerous Drugs (BNDD), answerable to the Department of Justice.

Lastly, in 1970, the *Comprehensive Drug Abuse Prevention and Control Act* abolished the patchwork of over 55 years of amendments to the Harrison Act and replaced this with an explicit categorization of drugs, seemingly the result of political compromises rather than scientific evaluation. By this act, drugs were classified into five schedules according to their abuse potential and therapeutic value; additions and reclassifications are made at the behest of the Attorney General.

In 1974 another administrational rearrangement dissolved the BNDD along with several competing satellite groups such as ODALE (Office of Drug Abuse Law Enforcement), LEAA (Law Enforcement Administration Agency) and those parts of the Customs Service which were concerned with the smuggling of drugs into the country. A new agency, the Drug Enforcement Administration (DEA) was created and given the power to enforce the regulations set forth in the 1970 act. This reorganization of agencies reflects and reinforces the concept that the "drug problem" encompasses all illicit drug use, that all illegal substances are inextricably linked and part of a single phenomenon. In contrast, alcohol remains subject to economic control through the Internal Revenue Service. In public attitudes, alcohol bears little resemblance to any of the drugs regulated by the DEA; it remains in many respects a "non-drug".

Historically, illicit drug use has received increasing public attention alongside steadily escalating penalties. Most illicit drugs are still available – laws don't seem to have stemmed the tide. Some experts feel that prohibitive measures have only led to the expansion of a black market which is free to raise its prices, adulterate its drugs, and introduce new and more hazardous substances, all of which have indeed made drug use an increasingly dangerous act.

E.M. Brecher in *Licit and Illicit Drugs* has fairly evaluated the present situation:

> *There is little likelihood that further tinkering with the laws – will prove more successful than the hundreds of such laws already on the books. Legislators who trust in such measures are failing to face the facts. Narcotic addiction remains endemic despite the most ingenuous laws and vigorous law enforcement. The time has come to end our dependence on repressive legislation and law enforcement as a cure for the narcotics evil, and to explore more rational alternatives.*

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