NINTH EDITION

DRUG USE AND ABUSE

A Comprehensive Introduction

HOWARD ABADINSKY

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HOWARD ABADINSKY
St. John's University

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Drug Use and Abuse: A Comprehensive Introduction, 9th Edition
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Dedicated to my wife
Caralyn Bishop-Abadinsky. My life has been blessed having
Caralyn at my side.

BRIEF CONTENTS

CONTENTS

PREFACE

The subject of drugs transcends many fields and disciplines: biology, counseling, history, law, law enforcement, political science, psychology, sociology, and social work—the literature is massive and diverse. The ninth edition brings this literature together in a comprehensive book.

The goal of this book is to provide the reader with an understanding of U.S. drug policy, its evolution and current status, and alternatives from throughout the world. In order to accomplish this task, the reader needs to understand drug pharmacology, psychology and sociology, prevention and treatment, history, trafficking, laws and law enforcement, each the subject of separate chapters. Without an understanding of these topics, an informed discussion of drug policy—the focus of Chapters 11 and 12—is not possible. And without an understanding of the dynamics of drugs, a discussion of the problem becomes an exercise equivalent to the proverbial blind men attempting to describe an elephant—each can accurately portray only that part he or she can touch. Because the language of drugs and drug use can be confusing, an expanded *glossary* is presented after Chapter 12.

ORGANIZATION

Drug Use and Abuse: *A Comprehensive Introduction* is organized into twelve chapters using a syllabus format for ease of classroom presentation. Each opens with chapter objectives and ends with a comprehensive summary and numerous review questions.

- *Chapter 1* explores the drug use continuum from abstinence to dependence and the slippery term *drug abuse*. Categories of drugs and methods for estimating their prevalence are explained, as well as the relationship between drugs, crime, and violence. The ninth edition provides new data on the prevalence of drug use and drug users.
- *Chapter 2* presents a history of psychoactive substances, beginning with the temperance movement and Prohibition, the patent medicine problem, and the intertwining of foreign affairs, the Opium Wars, and the Harrison Act. The chapter reviews opiates, the erratic popularity of cocaine in its various forms, the marijuana saga, the history of artificial depressants and stimulants, and natural and artificial hallucinogens. There is an examination of U.S. policy as it moved from indifference to the "war on drugs."

- *Chapter 3* explores the complex biology of psychoactive substances, but explanatory diagrams and easily understood prose reveal that it is "science for poets." This chapter prepares the reader for an examination of how specific drugs manipulate the organism to produce their effects, subjects of Chapters 4, 5, and 6. This chapter examines the disease model and genetic predisposition, as well as the roles of setting and expectations in producing a drug's effects. The chapter has been updated with the latest biological findings and streamlined for ease of understanding.
- *Chapter 4* focuses on stimulants ranging from caffeine and nicotine to cocaine and methamphetamine. The chapter explores how certain neurotransmitters play a major role, both in producing positive effects, such as euphoria, increased energy levels, enhanced mood, and lessening of depression, and in leading to dependence, damage to critical organs, and death. The chapter has been updated with the findings of current research.
- *Chapter 5* focuses on depressants, from natural opiates such as heroin, to the artificial, such as OxyContin, to alcohol and sedatives. It identifies the role of neurotransmitters, which while they can produce profound positive effects—euphoria, stress inhibition, and pain reduction—can also result in dependence, addiction, and death. The chapter has been updated with the findings of current research.
- *Chapter 6* examines hallucinogens, marijuana, and new synthetic drugs such as Spice and K2. Inhalants and the growing problem of the nonmedical use of prescription drugs are explored.
- *Chapter* 7 examines psychological and sociological theories that explain drug use and abuse. Combined with the biological views in Chapters 3 to 5, this chapter provides a full range of knowledge critical to an informed view of the causes of drug dependence and their policy implications. The chapter examines the two major branches of psychology, one based on psychoanalytic theory, the other on behavior/learning theory, and their explanations for drug abuse, while sociological theory places drug use and dependence in their social context. Psychological and sociological theories provide the basis for treatment discussed in Chapter 8.
- *Chapter 8* explores drug abuse prevention, its basic premises, exemplary programs, and research findings. This chapter reviews the various treatment approaches to substance abuse, ranging from the use of methadone and other chemicals, private and public programs, to in- and outpatient, twelve-step programs, and the therapeutic community. There is an analysis of the difficulty of evaluating drug program effectiveness and the lack of research support for much of what is offered as substance abuse treatment.
- *Chapter 9* provides a tour of the illicit drug economy as characterized by free-wheeling capitalism that responds only to market conditions of supply and demand as influenced by competitive violence and law enforcement efforts. There is an updated examination of the business of drugs, a world filled with private armies and violence, from its highest (international) levels down through mid-level wholesalers, and finally to the retail (street) level, and the connection between drug trafficking and terrorism. The chapter ends with a discussion of a critical element in the wholesale drug business: the various methods used to launder money.

- *Chapter 10* looks at the law enforcement response to the business of drugs as constrained by the U.S. Constitution and jurisdictional limitations. There is an examination of the various statutes used to investigate and prosecute drug offenders, such as conspiracy, tax, and money-laundering laws, as well as the investigative agencies and their techniques. The chapter concludes with an analysis of these techniques.
- *Chapter 11* ties together all of the previous chapters with an examination and critical analysis of U.S. drug policy in preparation for the discussion of policy alternatives used in other parts of the world, the subject of Chapter 12.
- *Chapter 12* extends the drug policy issue beyond U.S. borders by examining the approach taken in other parts of the world, in particular Europe where the alternative referred to as *harm reduction* has become popular. The chapter concludes with a comparative critique of drug legalization.

NEW TO THIS EDITION

Each chapter in the ninth edition opens with chapter learning objectives, which are linked to comprehensive bullet-point summaries at the ends of each chapter in addition to an extensive set of end-of-chapter review questions.

- Marginal notes in each chapter highlight critical issues.
- Chapter organization has been changed to better facilitate learning. The history of drug use and legislation was moved to the second chapter for better logic of classroom presentation.

Crucial chapter updates include the following:

- *Chapter 1* contains additional material on the connection between drug use and nondrug-use criminal behavior; it has been updated and expands the examination of how the prevalence of drug use is measured, and expands material on physician drug use and on the connection between alcohol, crime, and violence.
- *Chapter 2* is now "History of Drug Use and Drug Legislation," which was Chapter 8 in the previous edition, to make for ease of transition and contains updates to the history of drugs and drug abuse.
- *Chapter 3* expands on the central nervous system, dopamine, and Parkinson's disease, with a view toward simplifying for nonscience readers.
- *Chapter 4* contains additional material on intravenous ingestion of cocaine and methamphetamine use; new and expanded information on synthetic cathinones; extensive information on tobacco and e-cigarettes and caffeine, including new regulations on e-cigarettes; and a new discussion on selective serotonin reuptake inhibitors (SSRIs), such as Prozac.
- *Chapter 5* provides more information on fentanyl and kratom, and expansion of the discussion of alcohol.
- *Chapter 6* provides additional material on marijuana including JuJu Joints, dabbing, and synthetic cannabis, as well as hallucinogens, including ayahuasca and flakka. There is additional material on inhalants, and material on prescription drug abuse has been expanded.

- *Chapter 7* has increased material on the psychology and sociology of drug use.
- *Chapter 8* has been streamlined for ease of classroom use. There is an increase in information on buprenorphine, drug courts, and twelve-step programs, new material on motivational interviewing and alternatives to Alcoholics Anonymous, such as SMART Recovery. The chapter also contains additional material on cognitive behavior therapy and roadside drug tests.
- *Chapter 9* is now called "The Drug Business" and contains updates on the opium trade in Afghanistan, the expansion of Mexican and Colombian involvement in drug trafficking, and the role of China in providing precursor chemicals.
- *Chapter 10* contains updated material on drug law enforcement and INTERPOL.
- *Chapter 11* has new material on marijuana policy, policy resulting from a change in the drug-using population, and needle-exchange programs in the United States.
- *Chapter 12* is now called "Global Drug Policy" and expands information on drug policy in Portugal and contains additional material on Canadian drug policy and on the "harm reduction" policy.

INSTRUCTOR SUPPLEMENTS

MindTap® for *Drug Use and Abuse* in Criminal Justice

The most applied learning experience available, MindTap is dedicated to preparing students to make the kinds of reasoned decisions they will have to as criminal justice professionals faced with real-world challenges. Available for virtually every criminal justice course, MindTap offers customizable content, course analytics, an e-reader, and more—all within your current learning management system. With its rich array of assets—interactive visual summaries, decision-making scenarios, quizzes, and more—MindTap is perfectly suited to today's students of criminal justice, engaging them, guiding them toward mastery of basic concepts, and advancing their critical thinking abilities.

Online Instructor's Manual with Lesson Plans

The manual includes learning objectives, key terms, a detailed chapter outline, a chapter summary, lesson plans, discussion topics, student activities, "What If" scenarios, media tools, and sample syllabi. The learning objectives are correlated with the discussion topics, student activities, and media tools.

Cengage Learning Testing

Powered by Cognero, the accompanying assessment tool is a flexible, online system that allows you to:

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- Create ideal assessments with your choice of fifteen question types (including true/false, multiple-choice, opinion scale/Likert, and essay);

- Create multiple test versions in an instant, using drop-down menus and familiar, intuitive tools that take you through content creation and management with ease;
- Deliver tests from your Learning Management System (LMS), your classroom, or wherever you want—plus, import and export content into other systems as needed.

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The enhanced test bank includes a variety of questions per chapter—a combination of multiple-choice, true/false, completion, essay, and critical thinking formats, with a full answer key. The test bank is coded to the learning objectives that appear in the main text, and identifies where in the text (by section) the answer appears. Finally, each question in the test bank has been carefully reviewed by experienced criminal justice instructors for quality, accuracy, and content coverage so instructors can be sure they are working with an assessment and grading resource of the highest caliber.

Online PowerPoint Lectures

Helping you make your lectures more engaging while effectively reaching your visually oriented students, these handy Microsoft PowerPoint® slides outline the chapters of the main text in a classroom-ready presentation. The PowerPoint slides reflect the content and organization of the new edition of the text and feature some additional examples and real-world cases for application and discussion.

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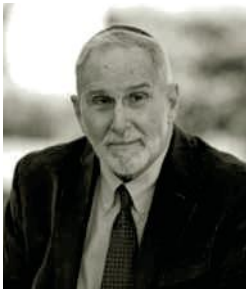

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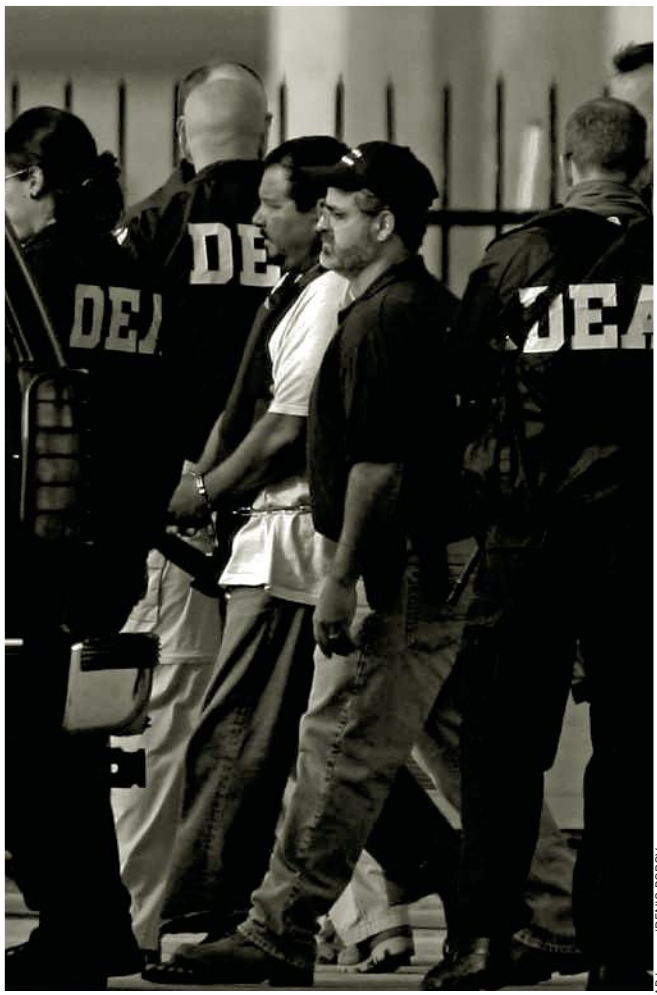
CHAPTER ONE

An Introduction to Drug Use and Abuse



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DEA agents escort a suspect taken from a U.S. Coast Guard ship to a waiting vehicle at the Coast Guard station in San Diego. The Coast Guard had detained drug smuggling suspects found on a fishing boat in the waters off of Baja California.

LEARNING OBJECTIVES

Chapter 1 will enable the reader to:

- Distinguish between drug *use* and drug *abuse*
- Understand the misuse of prescription drugs
- Learn how synthetic substances mimic the effects of popularly misused drugs
- Appreciate that there is no biological distinction between legal and illegal drugs
- Learn how alcohol influences the debate on drug misuse
- Recognize the difference between recreational and compulsive drug use
- Understand the critical importance of dysfunction in assessing drug use
- Appreciate the conflict between science and social values in discussing drugs
- Learn why societal views of drug use are based on those with problematic drug use
- Appreciate how availability influences who misuses drugs
- Understand the two primary methods for determining the amount of drug use

This chapter examines several issues: What is a drug? How do we distinguish between apples and aspirin? How do we distinguish between drug *use* and drug *abuse*? The term "abuse" is by definition pejorative—behavior that is harmful or improper—so whenever it is used, the connotation is negative: No one is in favor of abuse. What is the connection between drugs and criminal behavior? Later in this chapter, we will examine the methods used to determine how many persons use particular psychoactive substances and how much they use.

This book is concerned with psychoactive substances in three broad categories according to their primary effect on the central nervous system (CNS) (discussed in Chapter 3): depressants (discussed in Chapter 5), stimulants (discussed in Chapter 4), and hallucinogens (discussed in Chapter 6). A drug can have at least three different names: chemical, generic, and trade; and drugs that have a legitimate medical use may be marketed under a variety of trade names. In this book, trade names begin with a capital letter, while chemical or generic names are in lowercase.

1. **Depressants** depress the CNS (central nervous system) and can reduce pain. The most frequently used drug in this category is alcohol; the most frequently used illegal drug is the opiate derivative heroin. Other depressants, all of which have some medical use, include morphine, codeine, methadone, oxycodone, barbiturates, and tranquilizers. These substances can cause physical and psychological dependence—a craving—and withdrawal results in physical and psychological stress. Opiate derivatives (heroin, morphine, and codeine) and opium-like drugs such as methadone and oxycodone are often referred to as narcotics.
2. **Stimulants** elevate mood—produce feelings of well-being—by stimulating the CNS. The most frequently used drugs in this category are caffeine and nicotine; the most frequently used illegal stimulant is cocaine that, along with amphetamines, has some limited medical use.
3. **Hallucinogens** alter perceptual functions. The term *hallucinogen* rather than, for example, *psychoactive* or *psychedelic*, is a value-laden one. The most frequently used hallucinogens are LSD (lysergic acid diethylamide) and PCP (phencyclidine); both are produced chemically, and neither has a legitimate medical use. There are also organic hallucinogens, such as mescaline, which is found in the peyote cactus, and salvia, a mint-family plant native to Mexico.

There are a variety of chemicals that have a combination of these characteristics or are commonly grouped according to a nonchemical characteristic, such as "club drugs," a term used to characterize psychoactive substances associated with dance parties or *raves*, in particular MDMA, known as Ecstasy. Cannabis exhibits some of the characteristics of hallucinogens, depressants, and even stimulants. Inhalants include a variety of readily available products routinely kept in the home, such as glue, paint thinner, hair spray, and nail polish remover. They produce vapors that, when inhaled, can cause a psychoactive response. Prescription drugs are available lawfully only with a doctor's prescription and include opiates such as codeine and morphine as well as drugs used to treat depression and other disorders. According to the Office of National Drug Control Policy (2011a: 1), "prescription drug abuse is the Nation's fastest-growing drug problem," and according to the Centers for Disease Control and Prevention, overdose deaths involving opioid pain relievers exceed deaths from heroin and cocaine combined. "More high school seniors report recreational

use of tranquilizers or prescription narcotics like Oxycontin [oxycodone] and Vicodin, than heroin and cocaine combined" (Zuger 2011: D1).

There is a growing list of synthetic substances—designer drugs—that reputedly mimic the effects of the principal drugs in each of these categories with colorful names such as "Bath Salts," "Spice," "Dragon Fly," and "EightBallZ."

LEGAL VERSUS ILLEGAL: NICOTINE AND ALCOHOL

While statutes distinguish between lawful drugs such as nicotine and alcohol and illegal drugs such as heroin and cocaine, biology recognizes no such distinction.

While statutes distinguish between lawful drugs such as nicotine and alcohol and illegal drugs such as heroin and cocaine, biology recognizes no such distinction. Nicotine is a drug that meets the rigorous criteria for abuse liability and dependence potential, and "cigarettes are one of the major drugs of addiction in the United States and in the world and are responsible for more premature deaths than all of the other drugs of abuse combined" (Schuster 1992: 40). Our society makes artificial distinctions among psychoactive substances. "We foster the false impression that because nicotine and alcohol are legal, they must be less dangerous and less addictive than the illicit drugs" (Goldstein 2001: 4). "The legal distinction between licit and illicit drugs is sometimes treated as if it had pharmacological significance. Vendors of licit drugs and proponents of a 'drug-free society' share an interest in convincing tobacco smokers and alcohol drinkers that smoking and drinking are radically different than 'drug abuse.' But a nicotine addict can be just as hooked as a heroin addict, and the victim of an alcohol overdose is just as dead as the victim of a cocaine overdose" (Kleiman 1992: 7). David Courtwright (1982: 113) notes that by the twentieth century, smoking had become so widespread that cartoonists could use it as shorthand for famous public figures: Winston Churchill by his long cigar, FDR by his cigarette holder, and Douglas MacArthur by his corncob pipe. "Such personal use of tobacco had nothing to do with 'real' drugs."

The National Institute on Drug Abuse (NIDA) reports that nicotine dependence is the most common substance use disorder in the United States, and tobacco use is the leading preventable cause of death in the United States. Most of the more than 45 million people in the United States who smoke cigarettes fulfill classic criteria for drug dependence: they have difficulty stopping, have symptoms of withdrawal when they stop, show increased tolerance levels (discussed in Chapter 3), and continue despite knowledge of personal harm. Nicotine appears to have a dependence potential at least equal to that of other drugs. For example, among people who experiment with alcohol, 10 to 15 percent will meet criteria for alcohol dependence at some point in their life. Among people who experiment with cigarettes, 20 to 30 percent will meet criteria for nicotine dependence in their lifetime (American Psychiatric Association 1995). If "addiction" is defined as compulsive drug-seeking behavior, even in the face of negative health consequences, then tobacco use is certainly addiction (NIDA 2001d): the drug kills an estimated 440,000 persons annually, more than alcohol, illegal drug use, homicide, car accidents, and AIDS combined (*Tobacco Addiction* 2009). "Each day, more than 3,000 young persons smoke their first cigarette, and the likelihood of becoming addicted to nicotine is higher for these young smokers than for those who begin later in life" (Zickler 2002: 7). Youngsters aged 12 to 17 who smoke are about twelve times more likely to use illegal drugs and sixteen times more likely to drink heavily than youths who did not smoke. A 2015 study revealed

that an additional 60,000 deaths a year and five additional diseases had been linked to smoking tobacco (Grady 2015).

Distinctions between alcohol and other psychoactive drugs reflect neither reality nor science (Miller 1995). Indeed, heroin users have typically used marijuana and alcohol while they were adolescents, and from-heavy-alcohol-use-to-injecting-heroin is a typical sequence for most compulsive drug users (Inciardi, McBride, and Surratt 1998). "Both tobacco and alcohol share a role as 'gateway drugs' that presage use of other psychoactive drugs; in other words, alcohol and/or tobacco use precedes most subsequent use of marijuana and cocaine" (Shiffman and Balabanis 1995: 18). Thus, "there is a fairly consistent progression of adolescent substance use beginning with the licit drugs alcohol and/or cigarettes, moving on to illicit substances initiating with marijuana and progressing to cocaine and 'harder,' more problematic drugs" (Johnson, Boles, and Kleber 2000: 79).

Distinctions between alcohol and other psychoactive drugs reflect neither reality nor science.

THE WEED OF DEATH

"Smoking remains the leading cause of preventable death and disease in the United States, killing more than 443,000 Americans each year" (Harris 2012: 21).

According to scientific and pharmacological data used to classify dangerous substances for the protection of society, alcohol should be a Schedule II narcotic, a Drug Enforcement Administration (DEA) category referring to a substance that is highly addictive and available only with a government narcotic registry number. The cost of alcohol abuse is twice the social cost of all illegal drug abuse, more than $200 billion annually due to lost productivity, health care expenses, criminal justice costs, and other effects such as those related to fetal alcohol syndrome and associated disorders. According to the Centers for Disease Control and Prevention, while drug overdoses get more attention, alcohol use is actually responsible for more than twice as many deaths as drug use; it is the third leading preventable cause of death. And alcohol disturbs behavior in a way that "threatens the safety of others even when used occasionally and not compulsively" (Goldstein 2001: 5). About 80,000 Americans die annually from alcohol-related causes, with nearly two-thirds of these deaths attributable to car accidents and homicides and the rest caused by diseases like cirrhosis. Nevertheless, the 2011 edition of the DEA's *Drugs of Abuse* does not include alcohol (or tobacco).

Young people use alcohol more than illegal drugs, and the younger a person is when alcohol use begins, the greater the risk of developing alcohol abuse or dependence later in life. Alcohol use among the young strongly correlates with adult drug use. For example, adults who started drinking at early ages are nearly eight times more likely to use cocaine than adults who did not drink as children.

Young people use alcohol more than illegal drugs.

But alcohol for recreational use is legally manufactured, imported, sold, and possessed. Because of this reality, while it has been associated with a myriad of social problems, since the repeal of Prohibition in 1933 (discussed in Chapter 2), trafficking in alcohol has not been associated with rampant violence and corruption. Indeed, the repeal of Prohibition resulted in a dramatic decrease in the murder rate in the United States.

DRUGS, DRUG USE, DRUG ABUSE: THE DEFINITION ISSUE

The term ***drug*** is derived from the fourteenth-century French word *drogue*, meaning a dry substance—most pharmaceuticals at that time were prepared from dried herbs (Palfai and Jankiewicz 1991). There is no completely satisfying way of delineating what is and what is not a drug—for example, the differences between water, vitamin supplements, and penicillin (Goode 1989). Therefore, some feel it appropriate to refer to chemical or substance use. Imprecision in the use of the term *drug* has had serious social consequences.

Because alcohol is excluded from most people's definition of what is a drug, the public is conditioned to regard a martini as something fundamentally different from a marijuana cigarette, a barbiturate capsule, or a bag of heroin. Similarly, because the meaning of the word *drug* differs so widely in therapeutic and social contexts, the public is conditioned to believe that "street drugs" act according to entirely different principles than "medical drugs," alcohol, and nicotine do, with the result that the risks of the former are exaggerated and the risks of the latter are underrated (Uelmen and Haddox 1983).

"In contemporary society the word drug has two connotations—one positive, explaining its crucial role in medicine, and one negative, reflecting, not the natural and synthetic makeup of these chemicals, but the self-destruction and socially deleterious patterns of misuse" (Jones, Shainberg, and Byer 1979: 1). In this book, the term *drug* will refer to substances that have mood-altering, psychoactive effects. This definition includes caffeine, nicotine, and alcohol, as well as illegal chemicals such as cocaine and heroin.

Drug addiction is defined by the NIDA as "a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences" (*Science of Addiction* 2007: 5). In contrast, *drug abuse* implies the misuse of certain substances—it is a moral, not a scientific, term: "An unstandardized, value-laden, and highly relative term used with a great deal of imprecision and confusion, generally implying drug use that is excessive, dangerous, or undesirable to the individual or community and that ought to be modified" (Nelson et al. 1982: 33). Drug abuse "implies willful, improper use due to an underlying disorder or a quest for hedonistic or immoral pleasure" (Miller 1995: 10). Numerous definitions of *drug abuse* reflect social values, not scientific insight: "One reason for the prevalence of definitions of drug abuse that are neither logical nor scientific is the strength of Puritan moralism in American culture which frowns on the pleasure and recreation provided by intoxicants" (Zinberg 1984: 33). Such definitions typically refer to the "use of mood modifying chemicals outside of medical supervision, and in a manner which is harmful to the person and the community" (American Social Health Association 1972: 1). Other definitions, such as those offered by the World Health Organization and the American Medical Association, include references to physical and/or psychological dependency (Zinberg 1984).

Drug abuse is a moral, not a scientific, term.

The *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV), published by the American Psychiatric Association (1994: 182), refers to substance abuse as a "maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances. There may be repeated failure to fulfill major role obligations, repeated use in situations in which it is physically hazardous

[such as driving while intoxicated], multiple legal problems, and recurrent social and interpersonal problems."

In fact *drug abuse* may be defined from a number of perspectives: "The *legal* definition equates drug use with the mere act of using a proscribed drug or using a drug under proscribed conditions. The *moral* definition is similar, but greater emphasis is placed on the motivation or purpose for which the drug is used. The *medical* model opposes unsupervised usage but emphasizes the physical and mental consequences for the user, and the *social* definition stresses social responsibility and adverse effects on others" (Balter 1974: 5; emphasis added).

DRUG USE CONTINUUM

The *use* of psychoactive chemicals, licit or illicit, can objectively be labeled drug *abuse* only when the user becomes dysfunctional as a consequence; for example, he or she is unable to maintain employment, has impaired social relationships, exhibits dangerous—reckless or aggressive—behavior, and/or significantly endangers his or her health—sometimes referred to as *problem drug use*. Thus, drug *use*, as opposed to drug *abuse*, can be viewed as a continuum, as shown in Figure 1.1. At one end is the nonuser who does not use prohibited or abuse lawful psychoactive drugs. At the far end of the drug use continuum is the compulsive user whose life often revolves around obtaining, maintaining, and using a supply of drugs. For the compulsive user, failure to ingest an adequate supply of the desired drug results in psychological stress and discomfort, and there may also be physical withdrawal symptoms. Along the continuum is experimental use; socially endorsed use, which includes the use of drugs—wine or peyote, for example—in religious ceremonies, weddings, christenings, or at social functions such as "cocktail parties"; and recreational use. "Regardless of the duration of use, such people tend not to escalate their use to uncontrollable amounts." Long-term recreational users of cocaine, for example, can maintain patterns of use for a decade or more without loss of control. "Such use tends to occur in weekly or biweekly episodes and users perceive that the effects facilitate social functioning" (Siegel 1989: 222–223).

Understanding the use of psychoactive substances as a continuum allows the drug issue to be placed in its proper perspective: There is nothing inherently evil or virtuous about the use of psychoactive substances. For some—actually many—people, they make life more enjoyable; hence, the widespread use of caffeine, tobacco, and alcohol without serious social problems. For others, drugs become a burden as dependence brings dysfunction. In between these two extremes are a variety of drug *users*, such as the underage adolescent using tobacco or alcohol on occasion, as is very common in our society. Indeed, the definition of "underage" has undergone change: In New York, at age 18, I was able to legally purchase and use alcohol—a lot of beer in my college days. By 2009, all 50 states and the District of Columbia prohibited possession of

FIGURE 1.1
Drug Use Continuum

alcoholic beverages by those under age 21. (Twenty-five jurisdictions have some type of family exception.)

Adults may experiment with illegal drugs—marijuana and cocaine, for example—without moving up to more frequent, that is, recreational use. The recreational user enjoys some beer or cocktails on a regular basis or ingests cocaine or heroin just before or at social events, during which the drug eases social interaction for this actor. Outside of this specific social setting, the recreational user abstains and thereby remains in control of his or her use of drugs. Thus, even for cocaine, a very addictive drug, only 15 to 16 percent of users become dependent within ten years of first use (Robinson and Berridge 2003). For some, recreational use crosses into compulsive use marked by a preoccupation with securing and using drugs in the face of negative consequences, losing a job, severe disruption of social relationships, and/or involvement with the criminal justice system. Explanations for why some users cross over from occasional to compulsive use are discussed in subsequent chapters.

"The more spectacular consequences of cocaine abuse are not typical of the drug's effects as it is normally used any more than the phenomena associated with alcoholism are typical of the ordinary consumption of that drug" (Grinspoon and Bakalar 1976: 119). "Acknowledging potentially healthy relationships with drugs allows us to better identify unhealthy ones." Although this may sound heretical to those who readily categorize all illicit drug *use* as *abuse*, "the refusal to recognize healthy relationships with stigmatized drugs hinders our understanding of drug-related problems and healthy relationships with them" (Whiteacre and Pepinsky 2002: 27).

What we know about those who use psychoactive drugs is skewed toward compulsive users, particularly with respect to illegal drugs: Noncompulsive users have received very little research attention because they are hard to find: "Much data on users are gathered from treatment, law enforcement, and correctional institutions, and from other institutions allied with them. Naturally these data sources provide a highly selected sample of users: those who have encountered significant personal, medical, social, or legal problems in conjunction with their drug use, and thus represent the pathological end of the using spectrum" (Zinberg et al. 1978: 13). Such data "cannot be used to support a causal interpretation because of the absence of information on individuals who may have ingested a drug but had minimal or no negative consequences" (Newcomb and Bentler 1988: 13). Nevertheless, *definition determines response.*

What we know about those who use psychoactive drugs is skewed toward compulsive users.

Social expectations and definitions determine what kind of drug taking is appropriate and the social situations that are approved and disapproved for drug use. The use of drugs is neither inherently bad nor inherently good—these are socially determined values (Goode 1989). Thus, Mormons and Christian Scientists consider use of tea and coffee "abusive"; while Moslems and some Protestant denominations have the same view of alcohol, they permit tobacco smoking. The National Commission on Marijuana and Drug Abuse (1973: 13) argued that the term *drug abuse* "must be deleted from official pronouncements and public policy dialogue" because the "term has no functional utility and has become no more than an arbitrary codeword for that drug use which is presently considered wrong." As the history in Chapter 2 informs us, moderate use of a drug will be defined as *abuse* (and illegal) or it will be considered socially acceptable (and lawful) as society determines, regardless of the actual relative danger inherent in the substance. In other words, how society *defines* drug abuse determines how society *responds* to drug use.

DRUGS AND CRIME

A great deal of the concern over drugs is their connection to crime. The traditional way of considering the question of drug use and crime is the tripartite model offered by Paul Goldstein (1985):

1. *Pharmacological*: offenses that are psychopharmacology induced, that is, the result of a response to the intoxicating effects of a drug
2. *Economic-compulsive*: crime driven by a need to buy drugs
3. *Lifestyle*: drug use as part of a pattern of criminal behaviors not driven by or the result of drug use

Alex Stevens (2011) finds that Goldstein's tripartite model fails to account for drug users who are drawn into the drug subculture by the status and excitement it can offer. Through drugs they can become a *somebody*. "In a lifestyle of obtaining and spending money, of using and selling drugs, they can combine the mainstream values of work, success and consumption with the subterranean values of adventure, excitement and hedonism" (Stevens 2011: 45).

The outlawing of certain drugs makes the people using these chemicals (actually, the crime is "possession" of the drugs) criminals while substantially inflating the cost of the substances for the consumer. To secure their preferred substance, those using illegal drugs typically target sources of cash or salable property and/or sell drugs. While there is a criminal population whose nondrug law violations are based only on their desire to secure drugs, an unknown percentage, perhaps a majority, were criminals whose drug use is simply part of a pattern of hedonistic and antisocial behavior. Australian researchers (Torok et al. 2015: 13) found that when "comparing violent with non-violent IDUs [injecting drug users], it appears that the general liability to violent offending may be better explained by antisocial personality characteristics rather than substance use exposure." And the researchers conclude "that the liability to violent offending among IDUs is established quite early in the developmental course."

George Vaillant (1970: 488) reports that no matter what their class origins, most people who use narcotics "have a greater tendency than their socioeconomic peers to be delinquent," and even drug-abusing physicians "are relatively irresponsible before drug addiction."

Concern over the abuse of morphine by medical doctors dates back to at least the latter part of the nineteenth century (Mattison 1883), and in 1961, Charles Winick wrote of the physician addict, a loner who does not knowingly associate with other addicts. In fact, "diversion of prescription drugs for personal use by physicians is a significant problem in the United States" (Cummings, Merlo, and Cottler 2011: 195), and the addiction rate for physicians is estimated at anywhere from 30 to 100 times that for the population at large (Grosswirth 1982; Kennedy 1995; McDougal 2006). This has implications for prevention programs that focus on providing information about the dangers of drug use, discussed in Chapter 8. Eugene Boisaubin and Ruth Levine (2001: 32) note physician vulnerability: "In their early medical education [they] tend to overestimate their understanding of pharmacology and underestimate, or fail to comprehend, what addiction is and means. Overconfident in their belief that they can maintain 'control' over drugs and alcohol, and deluded that addiction is only a problem of 'street people,' medical students may continue to use and abuse throughout medical school and into residency." Of course availability, no matter the socioeconomic status, is a primary variable with respect to drug use. The relatively high rate of drug misuse among physicians can be explained by availability.

Research has determined that "youngsters who have conduct problems are more likely than others to be exposed to illicit drugs" (Swan n.d.: 1). Adolescents with emotional and behavioral problems are more likely to abuse alcohol, tobacco, and illicit drugs. Those who were inclined toward substance abuse admitted to delinquent behaviors such as stealing, cutting classes or skipping school, and hanging around with others who get into trouble. They also report poor peer and parental relations and problems such as difficulty concentrating in school or focusing attention on tasks at home, at part-time work, or even when involved in sports.

When compared to adolescents having fewer or less serious behavioral problems, those who repeatedly stole, showed physical aggression, or ran away from home were seven times as likely to be dependent on alcohol or illicit drugs. They were more than four times as likely to have used marijuana in the past month and seven times more likely to use other illicit drugs. They were nearly three times as likely to have used alcohol in the past month, three times as likely to have smoked cigarettes in the past month, and nearly nine times as likely to need treatment for drug abuse. According to the 2001 National Household Survey on Drug Abuse (discussed later), youths who engaged in violent behaviors during the past year were more likely to report past month alcohol and illicit drug use than were youths who did not engage in violent behaviors during the past year.

A study of male adolescent ninth- and tenth-graders in Washington, DC, found that for about half of those who used drugs (mostly marijuana), criminal behavior preceded use; for the other half, criminal behavior followed drug use. However, "those both using and selling drugs were more than twice as likely to have started using drugs before committing crimes as were those using but not selling drugs" (Brounstein et al. 1990: 3–4). In fact, we cannot be sure whether drug misuse leads to crime or criminals tend to misuse drugs (or perhaps neither); there are variables that lead to drug misuse, and the same variables lead to crime (McBride and McCoy 1981; Speckart and Anglin 1985, 1987). Indeed, areas with high levels of delinquency and crime also have high levels of drug usage, while the reverse is also true. In their study, Cheryl Carpenter and her colleagues (1988) found that the most seriously delinquent adolescents also used drugs, but crime and drug use appeared to be independent of one another, both apparently being related to other causal variables. In fact, extensive research informs us that a relatively small segment of youths commit a disproportionate amount of juvenile crime, and "the majority of serious crimes committed by youths are concentrated among serious delinquents who are also heavy users of alcohol and other drugs" (Johnson et al. 1991: 206). For these individuals, both drug use and crime appear to be part of a troubled lifestyle.

There is undoubtedly a high correlation between drug use and nondrug crime (Gandossy et al. 1980; Johnson et al. 1985; Nurco et al. 1985; Inciardi 1986; Wish and Johnson 1986; Kerr 1988). "A strong consensus has emerged in the research literature that the most frequent, serious offenders are also the heaviest drug users" (Visher 1990: 330). However, is it drug use that leads to criminal behavior? "It is clear that these two behaviors are associated over time, although there does not seem to be a clear progression from one to the other" (Mulvey, Schubert, and Chassin 2010: 3). "Substance use and serious offending fluctuate in similar patterns over time, suggesting a reciprocal or sequential relationship, but no causal relationship has been proven" (Mulvey, Schubert, and Chassin 2010: 1).

It is uncertain whether crime is a predrug use or postdrug use phenomenon.

The question of whether crime is a predrug use or postdrug use phenomenon is actually an oversimplification, and James Inciardi (1981: 59) argues, "the pursuit of some simple cause-and-effect relationship may be futile." His data found:

> *Among the males there seems to be a clear progression from alcohol to crime, to drug abuse, to arrest and then to heroin use. But on closer inspection the pattern*

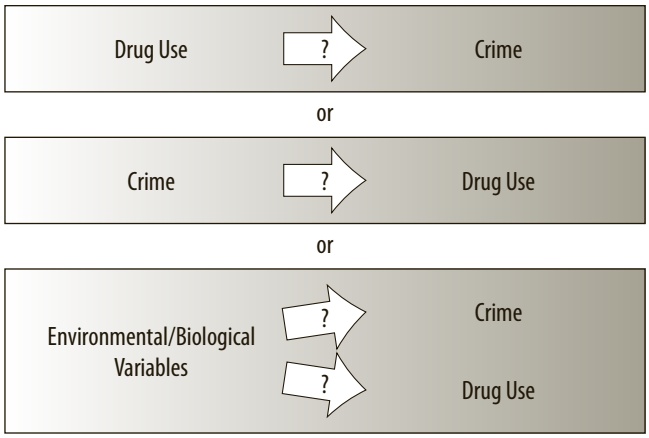
> *is not altogether clear. At one level, for example, criminal activity can be viewed as predating one's drug-using career, because the median point of the first crime is slightly below that of first drug abuse and is considerably before the onset of heroin use. But at the same time, if alcohol intoxication at a median age of 13.3 years were to be considered substance abuse, then crime is clearly a phenomenon that succeeds substance abuse. Among the females the description is even more complex. In the population of female heroin users criminal activity occurred after both alcohol and other drug abuse and marijuana use but before involvement with the more debilitating barbiturates and heroin.*

This issue has serious policy implications. If drug users simply continue in crime after they have given up drugs, efforts to reduce crime by reducing drug use are doomed to fail. As James Q. Wilson (1975: 137) points out, perhaps "some addicts who steal to support their habit come to regard crime as more profitable than normal employment. They would probably continue to steal to provide themselves with an income even after they no longer needed to use part of that income to buy heroin" or any other illegal substance. Douglas Anglin and George Speckart (1988: 223) found, however, "that levels of criminality after the addiction career [is over] are near zero, a finding that is compatible with data presented by other authors and is illustrative of the 'maturing out' phase of the addiction career 'life cycle.' "

In fact, the sequence of drug use and crime has produced contradictory findings (Huizinga, Menard, and Elliott 1989). For example, James Vorenberg and Irving Lukoff (1973) found that the criminal careers of a substantial segment of the heroin addicts they studied antedated the onset of heroin use. Furthermore, they found that those whose criminality preceded heroin use tended to be more involved in violent criminal behavior. Anglin and Speckart (1988) report that between 60 and 75 percent of the addicts in their samples had arrest histories that preceded addiction. Paul Cushman (1974: 43) found, however, that the heroin addicts he studied were predominantly noncriminal before addiction and experienced "progressively increased rates of annual arrests after addiction started." (Of course, this finding could be the result of addicts being less adept at crime.) Whatever the relationship—drug abuse leading to crime or criminals becoming drug abusers—some researchers (McGlothlin, Anglin, and Wilson 1978; Ball et al. 1979; Johnson, Lipton, and Wish 1986a) have found that the amount of criminality tends to be sharply reduced when people who have been narcotic addicts are no longer addicted. Furthermore, Bruce Johnson and his colleagues (1985, 1989) and Anglin and Speckart (1988) found that the more frequent the drug use, the more serious the types of crime committed, for example, burglary and robbery instead of shoplifting and other larcenies.

The National Institute of Justice concludes: "Assessing the nature and extent of the influence of drugs on crime requires that reliable information about the offense and the offender be available, and that definitions be consistent. In face of problematic evidence, it is impossible to say quantitatively how much drugs influence the occurrence of crime" (1995a: 3). While "there is a generally consistent overall pattern of positive and sometimes quite strong associations between illegal drug use and criminal behavior of other types," research has not been able to validate a causal link between drug use and criminal behavior (Anthony and Forman 2000: 27). While many different data sources establish a raw correlation between drug use and criminal offenses, correlation does not equal causation. Thus, drug use might cause (promote or encourage) crime, or criminality might cause (promote or encourage) drug use, and/or both may be caused (promoted or encouraged) by other variables—environmental, situational, and/or biological (MacCoun, Kilmer, and Reuter 2002; Figure 1.2).

FIGURE 1.2
Relationship between Drug Use and Crime: Three Possibilities



DRUG USE AND VIOLENCE

"The relationship between drugs and violence has been consistently documented in both the popular press and in social scientific research" (Goldstein 1985: 494). According to the DEA (2003: 16), "there is ample scientific evidence that demonstrates the links between drugs, violence, and crime. Drugs often cause people to do things they wouldn't do if they were rational and free of the influence of drugs." More than 50 years ago, Edwin Schur (1965) argued that narcotic addiction in the United States seems to reduce the inclination to engage in violent crime. However, a more recent research effort found that heroin users (not necessarily addicts) are at least as violent as, and perhaps more violent than, their non-drug-using or non-heroin-using criminal counterparts (Johnson, Lipton, and Wish 1986a), which is consistent with the writer's experience as a parole officer. In fact, the researchers report, "About half of the most violent criminals are heroin abusers" (Johnson, Lipton, and Wish 1986b: 3). It is difficult to determine whether this is simply a problem of changing definitions or one of a changing drug population. While there is no evidence that crime results from the direct effects of heroin itself—indeed, the substance appears to have a pacifying effect—the irritability resulting from withdrawal symptoms has been known to lead to violence (Goldstein 1985).

This writer dealt with heroin addicts for fourteen years and found many, if not most, to be quite capable of committing violent acts, including homicide—they were frequently convicted of violent crimes. In addition, as we shall discuss in Chapter 9, the drug distribution subculture at every level—from wholesaling to street sale—is permeated with extreme levels of violence. Many, perhaps most, drug users ingest more than one psychoactive chemical (polydrug abuse), thus expanding the possible behavioral effects of the different combinations. If the additional drug is alcohol, a relatively inexpensive substance, the drug–crime nexus is mitigated, at least for income-generating crimes. However, a great deal of violent noneconomic crime is linked to alcohol and crimes against persons and violence by drug users are often related to their use of alcohol (Dembo et al. 1991; Goldstein et al. 1991). A Canadian study found that alcohol-dependent prison inmates were twice as likely to have committed violent crimes as their most serious crime compared with prisoners who were dependent on other drugs ("Canadian Study Quantifies Link …" 2002). Similar findings were reported by Susan Martin and her colleagues (2004), who found that while cocaine was not associated with violent crime, alcohol was. While violence associated with

cocaine involved dealing, alcohol-related violence was usually the result of interpersonal disputes—insults and arguments involving intoxicated offenders.

Alcohol is an important element in a great deal of crime.

Alcohol is an important element in a great deal of crime: Drunk driving is the cause of about 10,000 deaths annually (National Institute on Alcohol Abuse and Alcoholism 2016). About half of all homicides and assaults are committed when the offender, victim, or both have been drinking. Each year, more than 600,000 students between the ages of 18 and 24 are assaulted by another student who has been drinking; and 95 percent of all violent crimes on college campuses involve the use of alcohol by the assailant, victim, or both (National Council on Alcoholism and Drug Dependence 2016).

But is there a causal link? Would the crimes have been committed in the absence of alcohol? Was alcohol used to provide "courage" for an act that was already being planned? One study found that "intoxication primarily affects adolescents who already have violent tendencies. These are the 'mean drunks' " (Felson, Teasdale, and Burchfield 2008: 137). Men with antisocial personality traits are more likely than other men to drink heavily and to commit a variety of aggressive and delinquent acts including sexual violence (Abbey and Ortiz 2011).

We know that alcohol consumption can lead to disinhibition, but what distinguishes "the life of the party" from the felonious assailant? Alcohol can impair the processing of information and judgment, thus causing a misinterpretation of events or the behavior of others, resulting, for example, in assault and/or aggressive sexual behavior such as "date rape." Intoxication can provide an excuse for engaging in socially disapproved behaviors, especially for men. The alcohol–sexual assault relationship may be due to factors that are the cause of both sexual violence and alcohol consumption (Abbey and Ortiz 2011).

Other drugs (e.g., PCP and cocaine) may involve otherwise normal people in violent behavior. Crack cocaine has been associated with violence, and there is a link between "street" violence surrounding the distribution of crack cocaine in disadvantaged neighborhoods. But as for the drug itself, research indicates that it is the type of person most likely to use crack, and not its pharmacology, that explains the crack–violence connection (Vaughn et al. 2010).

Of course, outlawing certain substances creates criminal opportunity for those daring enough to enter this market and they become part of a business that has no mechanisms for resolving disputes except violence.

ESTIMATING THE EXTENT OF DRUG USE

Most information on drug use in the United States is derived from two indicators: the National Survey on Drug Use and Health and Monitoring the Future.

Most information on drug use in the United States is derived from two indicators: the National Survey on Drug Use and Health (NSDUH) and Monitoring the Future (MTF). Two other programs to estimate drug use, Drug Abuse Warning Network and Arrestee Drug Abuse Monitoring, have been discontinued.

National Survey on Drug Use and Health

The Substance Abuse and Mental Health Services Administration (SAMHSA), an operating division within the U.S. Department of Health and Human Services, is charged with reducing the impact of substance abuse and mental illness on America's communities. SAMHSA publishes annual results from the NSDUH.

NSDUH is the primary source of statistical information on the use of illicit drugs in the United States. Called the National Household Survey on Drug Abuse (NHSDA) before 2002, it was conducted every two or three years between 1972 and 1990 and has been conducted annually since 1990. The survey provides data on incidence, prevalence, and trends

of the use of drugs by persons aged 12 and older living in households. The survey also covers residents and individuals in noninstitutional group quarters (e.g., shelters, boarding houses, college dormitories, migratory workers' camps, halfway houses). The survey excludes people with no fixed address (e.g., homeless people not in shelters), military personnel on active duty, and residents of institutional group quarters, such as jails, nursing homes, mental institutions, and long-term hospitals. The NHSDA sample was increased to more than 30,000 interviews in 1991 and to 68,000 interviews in 2014.

A professional interviewer makes a personal visit to each selected household. After answering a few general questions, one or two residents of the household may be asked to participate in the survey by completing an interview. It is possible no one will be selected for the interview. If an individual is selected for the interview, his or her participation is voluntary, but no other person can take their place. Since the survey is based on a random sample, each selected person represents more than 4,500 U.S. residents.

The interviewer conducts a screening of the eligible household with an adult resident (aged 18 or older) in order to determine whether zero, one, or two residents aged 12 or older should be selected for the interview. Data are collected using audio computer-assisted self-interviewing in which respondents read or listen to the questions on headphones and then enter their answers directly on the NSDUH laptop computer, so even the interviewer does not know the answer entered. For some less-sensitive items, the interviewer reads the question aloud and enters the participant's response into the computer. The interview takes about an hour to complete. To ensure confidentiality, full names are never recorded or associated with the participant's answers, and answers are protected by federal law and can only be used for statistical purposes. At the end of the completed interview, the selected person receives $30 in cash.

Survey drug categories include marijuana, cocaine, heroin, hallucinogens, inhalants, and nonmedical use of prescription-type pain relievers, tranquilizers, stimulants, and sedatives. There are also questions about lifetime, past month (i.e., current), and binge alcohol use, as well as the age at first alcohol use. Binge alcohol use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least one day in the past thirty days.

The resulting data are used in conjunction with MTF survey data (discussed next) to describe levels of drug use in specific segments of the population.

Monitoring the Future

MTF is a federally funded project at the Institute for Social Research of the University of Michigan; university staff members administer questionnaires to students, usually in the student classroom during a regular class period. Participation is voluntary and parents are notified well in advance to provide an opportunity to decline their child's participation. Questionnaires are self-completed and are formatted for optical scanning. In eighth and tenth grades, the questionnaires are completely anonymous, and in twelfth grade, they are confidential (name and address information is gathered separately from the twelfth-grade questionnaire to permit the longitudinal follow-up surveys of random subsamples of participants after high school).

MTF surveys eighth- to twelfth-grade students to assess patterns of drug use.

MTF annual surveys of high school seniors began in 1975, and eighth- and tenth-grade students were added in 1991. More than 45,000 students from about 400 public and private schools participate. The survey population is chosen to be representative of all students in U.S. public and private schools and students complete questionnaires in their classrooms every spring.

A standard set of three questions is used to determine *usage* levels for the various drugs (except for cigarettes and smokeless tobacco). For example: On how many occasions

(if any) have you used marijuana (a) in your lifetime? (b) during the past twelve months? (c) during the last thirty days? Each of the three questions is answered on a scale: 0, 1–2, 3–5, 6–9, 10–19, 20–39, and 40 or more occasions. For psychotherapeutic drugs such as amphetamines, barbiturates, tranquilizers, and prescription painkillers, respondents are instructed to include only use "on your own"—that is, without a doctor telling to you take them. For cigarettes, respondents are asked two questions about use: Have you ever smoked cigarettes? Never; once or twice; etc. Second: How frequently have you smoked cigarettes during the past thirty days? Not at all; less than one cigarette per day; one to five cigarettes per day; about one-half pack per day; etc. A parallel set of three questions asks about the frequency of being drunk. A different question asks: For the prior two-week period, how many times have you had five or more drinks in a row?

Perceived risk is measured by asking: How much do you think people risk harming themselves (physically or in other ways), if they try marijuana once or twice? No risk; slight risk; moderate risk; great risk; and can't say, drug unfamiliar.

Disapproval is measured by the question: Do you disapprove of people doing each of the following? Trying marijuana once or twice, etc.: don't disapprove; disapprove; and strongly disapprove. In the eighth- and tenth-grade questionnaires, there is a fourth category: can't say, drug unfamiliar.

Perceived availability is measured by the question: How difficult do you think it would be for you to get each of the following types of drugs, if you wanted some? Answer categories are: probably; impossible; very difficult; fairly difficult; fairly easy; and very easy. For eighth- and tenth-graders, there is another category: can't say, drug unfamiliar.

Primary uses of MTF data include (1) assessing the prevalence and trends of drug use among high school seniors and (2) gaining a better understanding of the lifestyles and value orientations associated with patterns of drug use and monitoring how these orientations are shifting over time. Follow-up surveys of representative subsamples of the original graduates that have been conducted for over a decade provide data on young adults and college students.

The survey has several limitations. High school dropouts (about 30 percent of students), who are associated with higher rates of drug use, are not part of the sampled universe. Chronic absentees, who may also have higher rates of abuse, are less likely to be surveyed. Conscious or unconscious distortions in self-reporting information can also bias results. In addition, new trends in drug abuse, such as the use of crack, might not be initially detected because the survey is designed to measure only drugs that are abused at significant levels.

DRUG USE BY THE NUMBERS

The data reveal that Americans have extraordinarily high levels of drug use: More than 27 million Americans aged 12 or older use illegal drugs, primarily marijuana, 22 million. Since 2005, there has been a significant decrease in cocaine use that in any form has about 1.5 million users; there are an estimated 425,000 heroin users. Tobacco use has declined to more than 50 million while alcohol use has remained steady with about 140 million drinkers.

By 2014, about one in twenty adolescents (4.9 percent) were current smokers. Adults who live below the poverty line are more likely to smoke than are those living above the poverty line, and high school dropouts are three times more likely to smoke than are college graduates. About 44.5 million adults describe themselves as smokers who had quit. About 9 million people have tried methamphetamine at least once, and current users are estimated to be less than one-half million. More than 22 million Americans aged 12 or older have used inhalants. Nonmedical users of prescription drugs are estimated at about 7 million.

SUMMARY OF CHAPTER 1

- Distinguishing between drug *use* and drug *abuse* is problematic.
- There are three broad categories of substances that affect the CNS.
- Prescription drugs are frequently misused for nonmedical purposes.
- Synthetic substances can mimic the effects of popularly misused drugs.
- Biology recognizes no distinction between legal stimulants such as tobacco and legal depressants such as alcohol and illegal stimulants and depressants.
- Nicotine dependence is the most common substance use disorder in the United States.
- Distinctions between alcohol and other psychoactive drugs reflect neither reality nor science.
- Young people use alcohol more than illegal drugs, and the younger a person is when alcohol use begins, the greater the risk of developing alcohol abuse or dependence later in life.
- "Street drugs" act according to the same principles as medical drugs, alcohol, and nicotine.
- Definitions of *drug abuse* reflect social values, not scientific insight.
- The *use* of psychoactive chemicals, licit or illicit, can objectively be labeled drug *abuse* only when the user becomes dysfunctional as a consequence.
- Recreational use of drugs is distinguished from compulsive use.
- Most users of psychoactive substances, legal or illegal, do not become compulsive users.
- Much data on those who misuse drugs are based on persons who have been arrested or are in treatment programs.
- Moderate use of a drug will be defined as *abuse* (and illegal) or it will be considered socially acceptable (and lawful) as society determines, regardless of the actual relative danger inherent in the substance.
- The connection between drug use and crime can be pharmacological, economic-compulsive, or lifestyle.
- Availability, no matter the socioeconomic status, is a primary variable with respect to drug use.
- We cannot be sure whether drug misuse leads to crime or criminals tend to misuse drugs.
- There are variables that lead to drug misuse, and the same variables lead to crime.
- The sequence of drug use and crime has produced contradictory findings.
- Alcohol is linked to a great deal of violent crime.
- Most information on drug use in the United States is derived from two indicators: the NSDUH and MTF.
- MTF has several limitations; for example, it does not include high school dropouts and those who are chronic absentees.

REVIEW QUESTIONS FOR CHAPTER 1

1. Why is distinguishing between drug *use* and drug *abuse* problematic?
2. What are the three broad categories of substances that affect the CNS?
3. What are synthetic drugs?
4. What is the most common substance use disorder in the United States?
5. What is the most widely used psychoactive substance among young people?
6. When can the *use* of psychoactive chemicals be objectively labeled drug abuse?
7. Why have noncompulsive users of illegal substances received little research attention?
8. What determines if drug use will be defined as drug abuse?
9. What are the three categories connecting drug use and crime?
10. What can explain the relatively high rate of drug misuse among physicians?
11. What has research found with respect to the sequence of drug use and crime?
12. What is the connection between alcohol and violent crime?
13. What are the two indicators upon which information on drug use in the United States is based?
14. What are two major limitations of MTF?

CHAPTER TWO

History of Drug Use and Drug Legislation

Keystone-France/Gamma-Keystone/Getty Images

On November 10, 1932, marchers in New York demand the repeal of Prohibition.

LEARNING OBJECTIVES

Chapter 2 will enable the reader to:

- Know how perceptions, beliefs, and attitudes with little empirical foundation influenced drug policies
- Appreciate how drug policy is handicapped by the lack of adequate data on the extent of drug use at earlier periods in our history and of alcohol use during Prohibition
- Learn how drug policy often reflected popular prejudices against racial and ethnic groups
- Understand why big business supported Prohibition
- Learn how Prohibition led to widespread disregard for law, corruption, and development of organized crime
- Appreciate how the repeal of Prohibition led criminal organizations into the drug trade
- Know that until 1914, morphine and heroin were available without a prescription
- Understand how opium was forced upon China by European powers
- Know that Chinese government's opposition to opium led to the "Opium Wars"
- Learn about the 1906 Pure Food and Drug Act

- Understand that American support for a ban on opiates was the result of international, not domestic, issues
- Learn how the Harrison Act impacted the medical profession
- Appreciate the effect of federal drug enforcement against physicians who dispensed opiates to addicts
- Understand how demographics influenced public interest in drugs
- Learn the role of the media in the rise of cocaine use in the 1960s
- Learn about the emergence of crack in the 1980s and its diminished use by 1989
- Appreciate how state laws against marijuana were connected to Mexican immigration
- Recognize the influence of drug scare campaigns
- Understand the influence of changes in the marijuana-using population
- Learn why the Food and Drug Administration launched a widespread anti-amphetamine campaign in the 1960s
- Appreciate the history of barbiturate use
- Learn how heavy advertising influenced the use of tranquilizers
- Understand the connection between hallucinogens and the antiestablishment movement of the 1960s
- Learn why during the 1960s there was greater interest in drug research and treatment
- Appreciate how drugs became a major political issue in the 1970s and 1980s
- Recognize the connection between increased use of methamphetamine and heroin and increased supply in the twenty-first century

The history of drug use and attempts at its control provide insight into the complexity of more contemporary control, enforcement, and social issues on this subject. Michael Botticelli (2015: v), director of National Drug Control Policy, points out: "Throughout much of the last century, our understanding of drug use was influenced by powerful myths and misconceptions about the nature of addiction. People who used illicit drugs and had substance use disorders were thought to be morally flawed or lacking in willpower. These views shaped our responses to drug policy, resulting in punitive rather than therapeutic approaches to reduce drug use."

As with many attempts at historical analyses, we are handicapped by the lack of adequate data on a number of items, particularly the extent of drug use at earlier periods in our history and of alcohol use during Prohibition. Providing an empirically based analysis of changing policies with respect to drugs is difficult without the ability to measure the effect of these changes, and in fact, we cannot provide such measurements.

Policy decisions, as we shall see in this chapter, have frequently been based on perceptions, beliefs, and attitudes with little empirical foundation. They have often reflected popular prejudices against a variety of racial and ethnic groups:[1] Race, religion, and ethnicity have been closely identified with the reaction to drugs in the United States: for example, the Irish and alcohol, the Chinese and opium, African Americans and cocaine, and Mexicans and marijuana. "What we think about addiction very much depends on who is addicted" (Courtwright 1982: 3). And sometimes policy has reflected concern over

[1] For an examination of the connection between drug legislation and racism, see Chambers (2011).

issues of international, rather than domestic, politics. Because the earliest drug prohibitions in the United States reflected a concern with alcohol, we will begin our examination with a history of that substance.

ALCOHOL AND THE TEMPERANCE MOVEMENT

Drinking alcoholic beverages for recreational purposes has an ancient history, with records of such use dating back more than 5,000 years. The Bible records that Noah planted a vineyard and drank the wine "and was drunken" (Genesis 9: 21). Later, we are told that the daughters of Lot made their father drunk with wine to trick him into propagating the family line (Genesis 19: 32–36). This unseemly use of alcohol could certainly serve as an object lesson against its use, but the practice of drinking alcoholic beverages appears near universal.

Americans have traditionally consumed large quantities of alcohol. "Early Americans drank alcohol at home and at work, and alcohol was ever-present in colonial social life" (White 1998: 1). When he retired from politics, George Washington built one of America's largest distilleries. His Mount Vernon distillery has been recreated using Washington's old recipe and offers whiskey for sale to tourists (Beschloss 2016). In 1785, Dr. Benjamin Rush, the surgeon general of the Continental Army and a signer of the Declaration of Independence, authored a pamphlet decrying the use of high-proof alcohol, which he claimed caused, among other maladies, moral degeneration, poverty, and crime. This helped to fuel the move toward Prohibition and inspired the establishment in 1808 of the Union Temperance Society, the first of many such organizations (Musto 1998). The society was superseded by the American Temperance Union in 1836, and the work of the union was supported by Protestant churches throughout the country. But the movement was divided over appropriate goals and strategies: Should moderation be preached, or should abstinence be forced through Prohibition? "Between 1825 and 1850, the tide turned toward abstinence as a goal and legal alcohol prohibition as the means" (White 1998: 5).

The abstinence view differs from the modern alcoholism movement in that it maintained that alcohol is inevitably dangerous for everyone: "Some people might believe they can drink moderately, but it is only a matter of time before they encounter increasing problems and completely lose control of their drinking." Thus, "as strange as it seems to us today, the temperance message thus was that alcohol is inevitably addicting, in the same way that we now think of narcotics" (Peele 1995: 37).

Opposition to alcohol was often intertwined with *nativism*, and efforts against alcohol and other psychoactive drugs were often a thinly veiled reaction to minority groups. (The early temperance movement, however, was strongly abolitionist.) Prohibitionists were typically rural, white Protestants antagonistic to urban Roman Catholics, particularly the Irish, who used the social world of the saloon to gain political power in large cities such as New York and Chicago (Abadinsky).

The temperance movement made great progress everywhere in the country, and it often coincided with the anti-immigrant sentiment that swept over the United States during the 1840s and early 1850s. In 1843, this led to the formation in New York of the American Republican Party, which spread nationally as the Native American Party, or

the "Know-Nothings." (Many clubs were secret, and when outsiders inquired about the group, they were met with the response "I know nothing.") Allied with a faction of the Whig Party, the Know-Nothings almost captured New York in 1854, and they did succeed in carrying Delaware and Massachusetts. They also won important victories in Pennsylvania, Rhode Island, New Hampshire, Connecticut, Maryland, Kentucky, and California. In 1855, the city of Chicago elected a Know-Nothing mayor, and prohibition legislation was enacted in the Illinois legislature (but was defeated in a public referendum that same year [Asbury 1950]). By 1855, about a third of the United States had prohibition laws, and other states were considering their enactment (Musto 1998). Slavery and abolition and the ensuing Civil War subsequently took the place of temperance as the day's most pressing issue (Buchanan 1992).

In 1869, the Prohibition Party attempted, with only limited success, to make alcohol a national issue. In 1874, the Women's Christian Temperance Union was established but was handicapped because its members lacked the franchise—women could not vote. Issues of temperance and nativism arose again strongly during the 1880s, leading to the formation of the American Protective Association, a rural-based organization that was strongly anti-Catholic and anti-Semitic. In 1893, the Anti-Saloon League was organized.

Around the turn of the century, these groups moved from efforts to change individual behavior to a campaign for national prohibition. After a period of dormancy, the prohibition movement was revived in the years 1907–1919 (Humphries and Greenberg 1981). By 1910, the Anti-Saloon League had become one of the most effective political action groups in U.S. history; it had mobilized Protestant churches behind a single purpose: to enact national prohibition (Tindall 1988). In 1915, nativism and prohibitionism fueled the rise of the Ku Klux Klan (KKK), and this time the KKK spread into Northern states and exerted a great deal of political influence. During World War I, an additional element, anti-German xenophobia, was added because brewing and distilling were associated with German immigrants (Cashman 1981).

Big business was also interested in Prohibition. Alcohol contributed to industrial inefficiency, labor strife, and the saloon, which served the interests of urban machine politics:

> *Around 1908, just as the Anti-Saloon League was preparing for a broad state-by-state drive toward national prohibition, a number of businessmen contributed the funds essential for an effective campaign. The series of quick successes that followed coincided with an equally impressive number of wealthy converts, so that as the movement entered its final stage after 1913, it employed not only ample financing but a sudden urban respectability as well. Substantial citizens now spoke about a new discipline with the disappearance of the saloon and the rampaging drunk. Significantly, prominent Southerners with one eye to the Negro and another to the poorer whites were using exactly the same arguments.* (Wiebe 1967: 290–291)

Workmen's compensation laws helped stimulate business support for temperance. Between 1911 and 1920, forty-one states had enacted workmen's compensation laws, and Sean Cashman (1981: 6) points out: "By making employers compensate workers for industrial accidents the law obligated them to campaign for safety through sobriety. In 1914, the National Safety Council adopted a resolution condemning alcohol as a cause of industrial accidents."

NATIONAL PROHIBITION

Acrimony between rural and urban America, between Protestants and Catholics, between Republicans and (non-Southern) Democrats, between "native" Americans and more recent immigrants, and between business and labor reached a pinnacle with the 1919 ratification of the Eighteenth Amendment. According to William Chambliss (1973: 10), Prohibition was accomplished by the political efforts of an economically declining segment of the American middle class: "By effort and some good luck this class was able to impose its will on the majority of the population through rather dramatic changes in the law." Andrew Sinclair (1962: 163) notes "national prohibition was a measure passed by village America against urban America." We could add that it was also passed by much of Protestant America against Catholic (and, to a lesser extent, Jewish) America: "Thousands of Protestant churches held thanksgiving prayer meetings. To many of the people who attended, prohibition represented the triumph of America's towns and rural districts over the sinful cities" (Sinclair 1962; Gusfield 1963; Coffey 1975: 7).

Mississippi became the first state to vote for Prohibition and the Eighteenth Amendment to the Constitution was ratified by the required thirty-sixth state, Nebraska, on January 16, 1919. According to its own terms, the amendment became effective on January 16, 1920. Ten months after its ratification, over a veto by President Woodrow Wilson, Congress passed the National Prohibition Act, usually referred to as the **Volstead Act** after its sponsor, Congressman Andrew Volstead of Minnesota. The Volstead Act strengthened the language of the amendment and defined as intoxicating all beverages containing more than 0.5 percent alcohol; it also provided for federal enforcement. Thus, the Prohibition Bureau, an arm of the Treasury Department, was created, soon becoming notorious for employing agents on the basis of political patronage.

In addition to being inept and corrupt, bureau agents were a public menace. By 1930, 86 federal agents and 200 civilians had been killed, many of them innocent women and children. Prohibition agents set up illegal roadblocks and searched cars; drivers who protested were in danger of being shot. Agents who killed innocent civilians were rarely brought to justice; when they were indicted by local grand juries, the cases were simply transferred, and the agents escaped punishment (Woodiwiss 1988). The bureau was viewed as a training school for bootleggers because agents frequently left the service to join their wealthy adversaries.

In the ninety days preceding the date the Eighteenth Amendment became effective, $500,000 worth of bonded whiskey was stolen from government warehouses, and afterward it continued to disappear (Sinclair 1962). Less than one hour after Prohibition went into effect, six armed men stole $100,000 worth of whiskey from two Chicago boxcars. In February 1920, a case of whiskey purchased in Montreal for $10 could easily be sold in New York for $80 (Coffey 1975). In fact, Canadians began making so much money from Prohibition that provinces with similar laws soon repealed them (Sinclair 1962). The heavily Catholic state of Rhode Island refused to ratify Prohibition and its 400 miles of coastline soon became awash with boats bringing in liquor from Canada. Newport, Rhode Island, is barely 200 nautical miles from Nova Scotia and Yarmouth where the Bronfman brothers, owners of the Seagram liquor empire, sold legal liquor at 65 cents a gallon to smugglers who resold in the United States for $7 a gallon (Krajicek 2007).

A limited amount of beer and wine could be made under the Prohibition law for personal consumption, and almost immediately, stores sprang up selling hops, yeast, malt,

cornmeal, grains, copper tubing, crocks, kettles, jugs, bottle tops, and other equipment for home distilling and brewing. Within one week of the onset of Prohibition, portable stills were on sale throughout the country (Asbury 1950; Kavieff 2000). This legal loophole was soon exploited for commercial purposes by organized crime.

The response of a large segment of the American population also proved to be a problem. People do not necessarily acquiesce to new criminal prohibitions, and general resistance can be fatal to the new norm (Packer 1968). Moreover, primary resistance or opposition to a new law such as Prohibition can result, secondarily, in disregard for laws in general—negative contagion. During Prohibition, notes Andrew Sinclair (1962: 292), a "general tolerance of the bootlegger and a disrespect for federal law were translated into a widespread contempt for the process and duties of democracy." This was exemplified by the general lawlessness that reigned in Chicago:

> *Banks all over Chicago were robbed in broad daylight by bandits who scorned to wear masks. Desk sergeants at police stations grew weary of recording holdups—from one hundred to two hundred were reported every night. Burglars marked out sections of the city as their own and embarked upon a course of systematic plundering, going from house to house night after night without hindrance. … Payroll robberies were a weekly occurrence and necessitated the introduction of armored cars and armed guards for the delivery of money from banks to business houses. Automobiles were stolen by the thousands. Motorists were forced to the curbs on busy streets and boldly robbed. Women who displayed jewelry in nightclubs or at the theater were followed and held up. Wealthy women seldom left their homes unless accompanied by armed escorts.* (Asbury 1950: 339)

The murder rate in the United States went from 6.8 per 100,000 persons in 1920 to 9.7 in 1933, the year Prohibition was repealed (Chapman 1991), after which it began to decline. And while the United States had local organized crime before Prohibition, there were no large crime syndicates (King 1969). Pre-Prohibition crime, insofar as it was organized, centered on corrupt political machines, vice entrepreneurs, and, at the bottom, gangs. The "Great Experiment" of Prohibition provided an opportunity for organized crime, especially violent forms, to blossom into an important force. Prohibition acted as a catalyst for the mobilization of criminal elements in an unprecedented manner, unleashing a heightened level of competitive violence and an unparalleled level of criminal organization (Abadinsky 2017). In 1933, when the repeal of Prohibition left a critical void in their business portfolios—they could not compete successfully with legitimate liquor entrepreneurs—criminal organizations turned to the drug trade.

OPIUM: A LONG HISTORY

The earliest "war against drugs" (other than alcohol) in the United States was a response to opium. Opium is the gum from the partially ripe seedpod of the opium poppy. There is no agreement on where the plant originated, and a great deal of debate surrounds its earliest use as a drug, which might date back to the Stone Age. The young leaves of the plant have been used as an herb for cooking and as a salad vegetable, and its small, oily seeds, which are high in nutritional value, can be eaten, pressed to make an edible oil, baked into poppy seed cakes, ground into poppy flour, or used as lamp oil. As a vegetal fat source "the seed oil could have been a major factor attracting early human groups to the opium poppy"

(Merlin 1984: 89). Archaeologists have discovered ancient art relics that may depict opium use in Egyptian religious rituals as early as 3500 B.C.E. (Inverarity, Lauderdale, and Field 1983). By 1500 B.C.E., the Egyptians had definitely discovered the medical uses of opium: It is listed as a pain reliever in the Ebers Papyrus (Burkholz 1987). From Egypt its use spread to Greece (O'Brien and Cohen 1984). Opium is discussed in Homer's works, the *Iliad* and the *Odyssey* (circa 700 B.C.E.), and the term "opium" is derived from the Greek word *opion*, meaning the juice of the poppy (Bresler 1980). Hippocrates (460–357 B.C.E.), the "father of medicine," recommended drinking the juice of the white poppy mixed with the seed of the nettle.

Opium was used by doctors in classical Greece and ancient Rome, and Arab traders brought it to China for use in medicine. Later, the Crusaders picked it up from Arab physicians and brought it back to Europe where it became a standard medicine. Opium is mentioned by Shakespeare in *Othello*, and by Chaucer, Sir Thomas Browne, and Robert Burton. In the early sixteenth century, physician Paracelsus made a tincture of opium—powdered opium dissolved in alcohol—that he called *laudanum*, and until the end of the nineteenth century it proved to be a popular medication (O'Brien and Cohen 1984).

Two centuries ago, opium was generally available as a cure for everything. It was like aspirin; every household had some, usually in the form of laudanum. Naturally, the general availability of opium and the medical profession's enthusiasm for it helped to create addicts, some of them very famous, such as Samuel Taylor Coleridge (1772–1834) and Thomas De Quincy (1785–1859). At the time medicine was primitive, doctors had no concept of addiction, and opium became the essential ingredient of innumerable remedies dispensed in Europe and America for the treatment of diarrhea, dysentery, asthma, rheumatism, diabetes, malaria, cholera, fevers, bronchitis, insomnia, and pain of any kind (Fay 1975). There was nothing to alert patients to the dangers of the medicines they were prescribed or to prepare them for the side effects. As a result no more stigma was attached to the opium habit than to alcoholism; it was an unfortunate weakness, not a vice. Wherever it was known, opium use was both medicinal and recreational (Alvarez 2001).

In explaining the popularity of opium, Charles Terry and Mildred Pellens (1928: 58) state: "When we realize that the chief end of medicine up to the beginning of the [nineteenth] century was to relieve pain, that therapeutic agents were directed at symptoms rather than cause, it is not difficult to understand the wide popularity of a drug which either singly or combined so eminently was suited to the needs of so many medical situations."

Opium is a labor-intensive product. To produce an appreciable quantity requires repeated incisions of a great number of poppy capsules: about 18,000 capsules—one acre—to yield 20 pounds of opium (Fay 1975). Accordingly, supplies of opium were rather limited in Europe until the eighteenth century, when improvements in plantation farming increased opium production. Attempts to produce domestic opium in the United States were not successful. While the poppy could be grown in many sections of the United States, particularly the South, Southwest, and California, labor costs and an opium gum that proved low in potency led to a reliance on imported opium (Morgan 1981).

Until 1914, opiates were available without a prescription.

As the primary ingredient in many "patent medicines" (actually secret formulas that carried no patent at all), opiates were readily available in the United States until 1914, and quacks prescribed and promoted them for general symptoms as well as for specific diseases. People who were not really ill were frightened into the patent medicine habit (Young 1961). Patients who were actually sick received the false impression that they were on the road to recovery. Of course, because there was often little or no scientific medical treatment for even the mildest of diseases, a feeling of well-being was at least psychologically,

and perhaps by extension physiologically, beneficial. However, babies born to opiate-using mothers were often small and experienced the distress of withdrawal. Harried mothers often responded by relieving them with infant remedies containing opium.

Chinese immigrants, who brought the habit with them to the United States, popularized the smoking of opium. During the latter part of the nineteenth and early twentieth centuries, they also operated commercial opium dens that often attracted the attention of the police, "not because of the use of narcotics but because they became gathering places for thieves, footpads [highwaymen] and gangsters." In fact, "opium dens were regarded as in a class with saloons and, for many years, were no more illegal" (Katcher 1959: 287).

Morphine and Heroin

At the end of the eighteenth century (Latimer and Goldberg 1981) or early in the nineteenth century (Bresler 1980; Nelson et al. 1982; Merlin 1984; Musto 1987), a German pharmacist poured liquid ammonia over opium and obtained an alkaloid, a white powder that he found to be many times more powerful than opium. Friedrich W. Serturner named the substance *morphium* after Morpheus, the Greek god of sleep and dreams; ten parts of opium can be refined into one part of morphine (Bresler 1980). It was not until 1817, however, that articles published in scientific journals popularized the new drug, resulting in widespread use by doctors. Quite incorrectly, as it turned out, the medical profession viewed morphine as an opiate without negative side effects.

By the 1850s, morphine tablets and a variety of morphine products were readily available without prescription. In 1856, the hypodermic method of injecting morphine directly into the bloodstream was introduced to U.S. medicine. The popularity of morphine rose during the Civil War, when the intravenous use of the drug to treat battlefield casualties was rather indiscriminate (Terry and Pellens 1928). Following the war, morphine use among ex-soldiers was so common as to give rise to the term *army disease*. Nevertheless, "Medical journals were replete with glowing descriptions of the effectiveness of the drug during wartime and its obvious advantages for peacetime medical practice" (Cloyd 1982: 21). Hypodermic kits became widely available, and the use of unsterile needles by many doctors and laypersons led to abscesses or disease (Morgan 1981).

In the 1870s, morphine was exceedingly cheap, cheaper than alcohol, and pharmacies and general stores carried preparations that appealed to a wide segment of the population, whatever the individual emotional quirk or physical ailment. Anyone who visited nearly any physician for any complaint, from a toothache to consumption, would be prescribed morphine (Latimer and Goldberg 1981), and the substance was widely used by physicians themselves. Morphine use in the latter part of the nineteenth century was apparently widespread in rural America (Terry and Pellens 1928).

Starting in the 1870s, doctors injected women with morphine to numb the pain of "female troubles" or to turn the "willful hysteric" into a manageable invalid. By the 1890s, when the first drug epidemic peaked, female medical addicts reportedly made up almost half of all addicts in the United States. In the twentieth century, the drug scene shifted to underworld elements of urban America, the disreputable "sporting class": prostitutes, pimps, thieves, gamblers, gangsters, entertainers, active homosexuals, and youths who admired the sporting men and women (Stearns 1998).

In 1874, a British chemist experimenting with morphine synthesized diacetylmorphine, and the most powerful of opiates came into being: "Commercial promotion of the new drug had to wait until 1898 when the highly respected German pharmaceutical

combine Bayer, in perfectly good faith but perhaps without sufficient prior care, launched upon an unsuspecting world public this new substance, for which they coined the trade name 'heroin' and which they marketed as—of all things—a 'sedative for coughs' " (Bresler 1980: 11). Jack Nelson and his colleagues (1982) state that heroin was actually isolated in 1898 in Germany by Heinrich Dreser, who was searching for a non-habit-forming pain reliever to take the place of morphine. Dreser named it after the German word *heroisch*, meaning large and powerful.

Opiates, including morphine and heroin, were readily available in the United States until 1914. In 1900, 628,177 pounds of opiates were imported into the United States (Bonnie and Whitebread 1970). The President's Commission on Organized Crime (PCOC) (1986) notes that between the Civil War and 1914, there was a substantial increase in the number of people using opiates. This was the consequence of a number of factors:

- The spread of opium smoking from Chinese immigrants into the wider community
- An increase in morphine addiction as a result of its indiscriminate use to treat battlefield casualties during the Civil War
- The widespread administration of morphine by hypodermic syringe
- The widespread use of opium derivatives by the U.S. patent medicine industry
- Beginning in 1898, the marketing of heroin as a safe, powerful, and nonaddictive substitute for the opium derivatives morphine and codeine.

China and the Opium Wars

Until the sixteenth century, China was a military power whose naval fleet surpassed any that the world had ever known. A fifteenth-century power struggle ultimately led to a regime dominated by Confucian scholars; in 1525 they ordered the destruction of all oceangoing ships and set China on a course that would lead to poverty, defeat, and decline (Kristoff 1999).

In 1626 a British warship appeared off the coast of China, and its captain imposed his will on Canton (now Guangzhou) with a bombardment. In response to the danger posed by British ships, the emperor opened the city of Canton to trade, and Britain granted the British East India Company a monopoly over the China trade. Particularly important to this trade was the shipping of tea to England. By the 1820s, the trade situation between England and China paralleled current trade between the United States and China. Although British consumers had an insatiable appetite for Chinese tea, the Chinese desired few English goods. The British attempted to introduce alcohol, but a large percentage of Asians have enzyme systems that make drinking alcohol extremely unpleasant. Opium was different (Beeching 1975). Poppy cultivation was an important source of revenue for the Mughal emperors (Muslim rulers of India between 1526 and 1857). When the Mughal empire fell apart, the British East India Company salvaged and improved the system of state control of opium. In addition to the domestic market, the British supplied Indian opium to China.

Opium was first prohibited by the Chinese government in Peking (Beijing) in 1729, when only small amounts of the substance were reaching China. Ninety years earlier, tobacco had been similarly banned as a pernicious foreign article. Opium use was strongly condemned in China as a violation of Confucian principles, and for many years, the imperial decree against opium was generally supported by the population (Beeching 1975). In 1782 a British merchant ship's attempt to sell 1,601 chests of opium

in China resulted in a total loss, as no purchasers could be found. By 1799, however, a growing traffic in opium led to an imperial decree condemning the trade. Dean Latimer and Jeff Goldberg (1981) doubt that opium addiction was extensive or particularly harmful to China as a whole. The poorer classes, the authors note, could afford only adulterated opium, which was unlikely to produce addiction. "Just why the Chinese chose to obtain their supplies from India," states Peter Fay (1975: 11–12), "is no clearer than why, having obtained it, they smoked it instead of ate it." In the end, he notes, the Chinese came to prefer the Indian product to their own. However, because the preference was to smoke opium, it had to be specially prepared by being boiled in water, filtered, and boiled again until it reached the consistency of molasses, thereby becoming "smoking opium."

Like the ban on tobacco, the one on opium was not successful (official corruption was endemic in China). As consumption of imported opium increased and the method of ingestion shifted from eating to smoking, official declarations against opium increased, and so did smuggling. "When opium left Calcutta, stored in the holds of country ships and consigned to agents in Canton, it was an entirely legitimate article. It remained an entirely legitimate article all the way up to the China Sea. But the instant it reached the coast of China it became something different. It became contraband" (Fay 1975: 45). In fact, the actual shipping of opium to China was accomplished by independent British or Parsee merchants. Thus, notes Beeching, "the Honourable East India Company was able to wash its hands of all formal responsibility for the illegal drug trade" (1975: 26).

Opium furnished the British with the silver needed to buy tea. Because opium was illegal in China, however, its importation—smuggling—brought China no tariff revenue. Before 1830 opium was transported to the coast of China, where it was offloaded and smuggled by the Chinese themselves. The outlawing of opium by the Chinese government led to the development of an organized underworld; gangs became secret societies—triads—that still move heroin out of the Far East to destinations all over the world (Latimer and Goldberg 1981). (This will be discussed in Chapter 9.) The armed opium ships were safe from Chinese government intervention, and the British were able to remain aloof from the smuggling itself.

In the 1830s, the shippers grew bolder and entered Chinese territorial waters with their opium cargo. The British East India Company, now in competition with other opium merchants, sought to flood China with cheap opium and drive out the competition (Beeching 1975). In 1837 the emperor ordered his officials to move against opium smugglers, but the campaign was a failure, and the smugglers grew even bolder. The following year the emperor changed his strategy and moved against Chinese traffickers and drug users, as only a total despot could do, helping to dry up the market for opium. As a result, the price fell significantly (Hanes and Sanello 2005).

THE FIRST OPIUM WAR. In 1839, in a dramatic fashion, Chinese authorities laid siege to the port city of Canton, confiscating and destroying all opium waiting offloading from foreign ships. The merchantmen agreed to stop importing opium into China, and the siege was lifted. The British merchants petitioned their government for compensation and retribution. The reigning Parliamentary Whig majority was very weak, however, and compensating the opium merchants was not politically or financially feasible. Instead, the cabinet, without parliamentary approval, decided on a war that would result in the seizure of Chinese property (Fay 1975).

In 1840, a British expedition attacked the poorly armed and poorly organized Chinese forces. In the rout that followed, the emperor was forced to pay $6 million for the opium his officials had seized and $12 million as compensation for the war. Hong Kong became a Crown colony, and the ports of Canton, Amoy (Xiamen), Foochow (Fuzhou), Ningpo, and Shanghai were opened to British trade. Opium was not mentioned in the peace (surrender) treaty, but the trade resumed with new vigor. In a remarkable reversal of the balance of trade, by the mid-1840s China had an opium debt of about 2 million pounds sterling (Latimer and Goldberg 1981). In the wake of the First Opium War, China was laid open to extensive missionary efforts by Protestant evangelicals, who, although they opposed the opium trade, viewed saving souls as their primary goal. Christianity, they believed, would save China from opium (Fay 1975). Unfortunately, Catholic and Protestant missionaries actively promoted morphine as an agent for detoxifying opium addicts (Latimer and Goldberg 1981).

OPIUM PROFITS

At the end of the nineteenth century "there was little interest in suppressing a business that was so profitable for opium merchants, shippers, bankers, insurance agencies and governments. Many national economies were as dependent on opium as the addicts themselves. Indeed, what Karl Marx described as 'the free trade in poison' was such an important source of revenue for Great Powers that they fought for control of opium markets" Antonio Maria Costa (2009: 3).

SECOND OPIUM WAR. The Second Opium War began in 1856, when the balance of payments once again favored China. In that year, a minor incident between the British and Chinese governments was used as an excuse to force China into making further treaty concessions. This time the foreign powers seeking to exploit a militarily weak China included Russia, the United States, and particularly France, which was jealous of the British success. Canton was sacked, and a combined fleet of British and French warships sailed right up the Grand Canal to Peking and proceeded to sack and burn the imperial summer palace, 200 buildings spread over eighty square miles of carefully landscaped parkland with extensive libraries and priceless works of art (Hanes and Sanello 2005).

The emperor was forced to indemnify the British 20,000 pounds sterling, more than enough to offset the balance of trade which was the real cause of the war. A commission was appointed to legalize and regulate the opium trade (Latimer and Goldberg 1981) that increased from less than 59,000 chests a year in 1860 to more than 105,000 by 1880 (Beeching 1975). Until 1946, the British permitted the use of opiates in their Crown colony of Hong Kong, first under an official monopoly and, after 1913, directly by the government (Lamour and Lamberti 1974). During Japan's occupation of China, which began a few years before its attack on Pearl Harbor, large amounts of heroin were trafficked by the Japanese army's "special services branch," which helped to finance the cost of the occupation (Karch 1998).

The Chinese Problem and the American Response

Chinese laborers were originally brought into the United States after 1848 to work in the gold fields, particularly in those aspects of mining that were most dangerous because few white men were willing to engage in blasting shafts, placing beams, and laying track lines in the gold mines. Chinese immigrants also helped to build the Western railroad lines at pay few

whites would accept—known as "coolie wages." After their work was completed, the Chinese were often banned from the rural counties; by the 1860s, they were clustering in cities on the Pacific coast, where they established Chinatowns—and where many of them smoked opium.

The British opium monopoly in China was challenged in the 1870s by opium imported from Persia and cultivated in China itself. In response, British colonial authorities, heavily dependent on a profitable opium trade, increased the output of Indian opium, causing a price decline that was aimed at driving the competition out of business. The resulting oversupply increased the amount of opium entering the United States for the Chinese population.

Beginning in 1875, there was an economic depression in California. As a result, the first significant piece of prohibitionary drug legislation in the United States was enacted by the city of San Francisco. "The primary event that precipitated the campaign against the Chinese and against opium was the sudden onset of economic depression, high unemployment levels, and the disintegration of working-class standards of living" (Helmer 1975: 32). The San Francisco ordinance prohibited the operation of opium dens, commercial establishments for the smoking of opium, "not because of health concerns as such, but because it was believed that the drug stimulated coolies into working harder than non-smoking whites" (Latimer and Goldberg 1981: 208). Throughout the latter part of the nineteenth century, Chinese Americans were demonized, particularly in the West (Pfaelzer 2007).

Depressed economic conditions and xenophobia led one Western state after another to follow San Francisco's lead and enact anti-Chinese legislation that often included prohibiting the smoking of opium. The anti-Chinese nature of the legislation was noted in some early court decisions. In 1886 an Oregon district court, responding to a petition for habeas corpus filed by Yung Jon, who had been convicted of opium violations, stated: "Smoking opium is not our vice, and therefore it may be that this legislation proceeds more from a desire to vex and annoy the 'Heathen Chinese' in this respect, than to protect the people from the evil habit. But the motives of legislators cannot be the subject of judicial investigation for the purpose of affecting the validity of their acts" (Bonnie and Whitebread 1970: 997).

"After 1870 a new type of addict began to emerge, the white opium smoker drawn primarily from the underworld of pimps and prostitutes, gamblers, and thieves" (Courtwright 1982: 64). During the 1890s, Chicago's Chinatown was located in the notorious First Ward, whose politicians grew powerful and wealthy by protecting almost every vice known to humanity. But First Ward alderman John "Bathhouse" Coughlin "couldn't stomach" opium smokers and threatened to raid the dens himself if necessary. There was constant police harassment, and in 1894 the city enacted an anti-opium ordinance. By 1895, the last of the dens had been raided out of business (Sawyers 1988).

Anti-Chinese efforts were supported and advanced by Samuel Gompers (1850–1924) as part of his efforts to establish the American Federation of Labor. The Chinese served as scapegoats for organized labor that depicted the "yellow devils" as undercutting wages and breaking strikes. Anti-opium legislation was also fostered by stories of white women being seduced by Chinese white slavers through the use of opium.[2] In 1882, the Chinese Exclusion Act banned the entry of Chinese laborers into the United States. (It was not until 1943, when the United States was allied with China in a war against Japan, that citizenship rights were extended to Chinese immigrants, and China was then permitted an annual immigration of 105 individuals.)

[2] Similar anti-Chinese hysteria, especially the diatribe that they used opium to seduce white women, led to anti-opium legislation in Australia at the end of the nineteenth century (Manderson 1999).

In 1883, Congress raised the tariff on the importation of smoking opium. In 1887, apparently in response to obligations imposed on the United States by a Chinese-American commercial treaty negotiated in 1880 and becoming effective in 1887, Congress banned the importation of smoking opium by Chinese subjects. Americans, however, were still permitted to import the substance, and many did so, selling it to both Chinese and American citizens (PCOC 1986). The Tariff Act of 1890 increased the tariff rate on smoking opium to $12 per pound, resulting in a substantial increase in opium smuggling and the diversion of medicinal opium for manufacture into smoking opium. In response, in 1897 the tariff was reduced to $6 per pound (PCOC 1986).

During the nineteenth century, opiates were not associated with crime in the public mind: While some people may have frowned on opium use as immoral,

> *employees were not fired for addiction. Wives did not divorce their addicted husbands or husbands their addicted wives. Children were not taken from their homes and lodged in foster homes or institutions because one or both parents were addicted. Addicts continued to participate fully in the life of the community. Addicted children and young people continued to go to school, Sunday School, and college. Thus, the nineteenth century avoided one of the most disastrous effects of current narcotics laws and attitudes: the rise of a deviant addict subculture, cut off from respectable society and without a road back to respectability.* (Brecher et al. 1972: 6–7)

The Pure Food and Drug Act

National efforts against opiates (and cocaine) were part of a larger campaign to regulate drugs and the contents of food substances; in 1879, a bill was introduced in Congress to accomplish national food and drug regulation. These efforts were opposed by the Proprietary Association of America, which represented the patent medicine industry. The medical profession was more interested in dealing with quacks within the profession than with quack medicines, and the American Pharmaceutical Association was of mixed mind: Its members, in addition to being scientists, were merchants who found the sale of proprietary remedies bulking large in their gross income (Young 1961). Toward the end of the nineteenth century, the campaign for drug regulation was assisted by agricultural chemists who decried the use of chemicals to defraud consumers into buying spoiled canned and packaged food. In 1884, state-employed chemists formed the Association of Official Agricultural Chemists to combat this widespread practice. They began to expand their efforts into non-foodstuffs, including patent medicines.

The nation's newspapers and magazines made a considerable amount of money from advertising patent medicines. Toward the turn of the century, however, a few periodicals, in particular *Ladies Home Journal* and *Collier's*, began vigorous investigations and denunciations of patent medicines. Eventually, the American Medical Association (AMA, founded in 1847), which was a rather weak organization at the close of the nineteenth century because the vast majority of doctors were not members (Musto 1973), began to campaign in earnest for drug regulation.

U.S. Senate hearings on the pure food issue gained a great deal of newspaper coverage and aroused the public (Young 1961). The dramatic event that quickly led to the adoption of the Pure Food and Drug Act, however, was the 1906 publication of Upton Sinclair's *The Jungle* (1981/1906). Sinclair, in a novelistic description of the meat industry in Chicago, exposed the filthy, unsanitary, and unsafe conditions under which food reached the

consumer. Sales of meat fell by almost 50 percent, and President Theodore Roosevelt dispatched two investigators to Chicago to check on Sinclair's charges. Their "report not only confirmed Sinclair's allegations, but added additional ones. Congress was forced by public opinion to consider a strong bill" (Ihde 1982: 42). The result was the Pure Food and Drug Act, passed later that same year, which required medicines to list certain drugs and their amounts, including alcohol and opiates.

China and the International Opium Conference

The international U.S. response to drugs in the twentieth century is directly related to trade with China. To increase influence in China and thus improve its trade position, the United States supported the International Reform Bureau (IRB), a temperance organization representing over thirty missionary societies in the Far East, which was seeking a ban on opiates. As a result, in 1901 Congress enacted the Native Races Act, which prohibited the sale of alcohol and opium to "aboriginal tribes and uncivilized races." The provisions of the act were later expanded to include "uncivilized elements" in the United States proper: Indians, Eskimos, and Chinese (Latimer and Goldberg 1981).

As a result of the Spanish–American War in 1898, the Philippines were ceded to the United States. At the time of Spanish colonialism, opium smoking was widespread among Chinese workers on the islands. Canadian-born Reverend Charles Henry Brent (1862–1929), a supporter of the IRB, arrived in the Philippines as the Episcopal bishop during a cholera epidemic that began in 1902 and that reportedly had led to an increase in the use of opium. As a result of his efforts, in 1905 Congress enacted a ban against sales of opium to Filipino natives except for medicinal purposes. Three years later, the ban was extended to all residents of the Philippines. It appears that the legislation was ineffective, and smoking opium remained widely available (Musto 1973). "Reformers attributed to drugs much of the appalling poverty, ignorance, and debilitation they encountered in the Orient. Opium was strongly identified with the problems afflicting an apparently moribund China. Eradication of drug use was part of America's white man's burden and a way to demonstrate the New World's superiority" (Morgan 1974: 32).

Bishop Brent proposed the formation of an international opium commission to meet in Shanghai in 1909. This plan was supported by President Theodore Roosevelt, who saw it as a way of assuaging Chinese anger at the passage of the Chinese Exclusion Act (Latimer and Goldberg 1981). The International Opium Commission, chaired by Brent and consisting of representatives from thirteen nations, convened in Shanghai on February 1. Brent was successful in rallying the conferees around the U.S. position that opium was evil and had no nonmedical use. The commission unanimously adopted a number of vague resolutions; the most important are as follows (Terry and Pellens 1928):

1. Each government to take action to suppress the smoking of opium at home and in overseas possessions and settlements
2. Opium has no use outside of medicine and, accordingly, each country should move toward increasingly stringent regulations concerning opiates
3. Measures should be taken to prevent the exporting of opium and its derivatives to countries that prohibit its importation.

Only the United States and China, however, were eager for future conferences, and legislative efforts against opium following the conference were generally unsuccessful.

Southerners were distrustful of federal enforcement, and the drug industry was opposed. Efforts to gain Southern support for antidrug legislation focused on the alleged use of cocaine by African Americans—the substance was reputed to make them uncontrollable. Although tariff legislation with respect to opium already existed, Terry and Pellens (1928) note that its purpose was to generate income. The first federal legislation to control the domestic use of opium was passed in 1909 as a result of the Shanghai conference. "An Act to prohibit the importation and use of opium for other than medicinal purposes" failed to regulate domestic opium production and manufacture, nor did it control the interstate shipment of opium products, which continued to be widely available through retail and mail order outlets (PCOC 1986).

A second conference was held in The Hague in 1912, with the United States, Turkey, Great Britain, France, Portugal, Japan, Russia, Italy, Germany, Persia, the Netherlands, and China in attendance. A number of problems stood in the way of an international agreement: Germany wished to protect its burgeoning pharmaceuticals industry and insisted on a unanimous vote before any action could be agreed upon; Portugal insisted on retaining the Macao opium trade; the Dutch demanded to maintain their opium trade in the West Indies; and Persia and Russia wanted to keep on growing opium poppies. Righteous U.S. appeals to the delegates were rebuffed with allusions to domestic usage and the lack of laws in the United States (Latimer and Goldberg 1981). Nevertheless, the conference managed to put together a patchwork of agreements known as the International Opium Convention, which was ratified by Congress on October 18, 1913. The signatories committed themselves to enacting laws aimed at suppressing the use of opium, morphine, and cocaine as well as drugs prepared or derived from these substances (PCOC 1986). On December 17, 1914, President Woodrow Wilson approved the Harrison Act, which represented this country's attempt to carry out the provisions of The Hague Convention.

The Harrison Act

The Harrison Act provided that any person who was in the business of dealing in drugs covered by the act, including the opium derivatives morphine and heroin, as well as cocaine, was required to register annually and to pay a special annual tax of $1. The statute made it illegal to sell or give away opium or opium derivatives and coca or its derivatives without a written order on a form issued by the commissioner of revenue. People who were not registered were prohibited from engaging in interstate traffic in the drugs, and no one could possess any of the drugs, who had not registered and paid the special tax, under a penalty of up to five years imprisonment and a fine of no more than $2,000. Rules promulgated by the Treasury Department permitted only medical professionals to register, and they had to maintain records of the drugs they dispensed. Within the first year more than 200,000 medical professionals registered, and the small staff of Treasury agents could not scrutinize the number of prescription records that were generated (Musto 1973).

It was concern with federalism—constitutional limitation on the police powers of the central government—that led Congress to use the taxing authority of the federal government to control drugs. While few people today would question the Drug Enforcement Administration's (DEA) right to register physicians and pharmacists and control what drugs they can prescribe and dispense, at the beginning of the twentieth century, federal authority to regulate narcotics and the prescription practices of physicians was generally

thought to be unconstitutional (Musto 1998). In 1919, use of taxing authority to regulate drugs was upheld by the Supreme Court (*United States v. Doremus* 249 U.S. 86):

> *If the legislation enacted has some reasonable relation to the exercise of the taxing authority conferred by the Constitution, it cannot be invalidated because of the supposed motives which induced it. … The Act may not be declared unconstitutional because its effect may be to accomplish another purpose as well as the raising of revenue. If the legislation is within the taxing authority of Congress—that is sufficient to sustain it.*

The Harrison Act was enacted with the support of the AMA and the American Pharmaceutical Association, both of which had grown more powerful and influential in the first two decades of the twentieth century, since the medical profession had been granted a monopoly on dispensing opiates and cocaine. The Harrison Act also had the effect of imposing a stamp of illegitimacy on the use of most narcotics, fostering an image of the immoral and degenerate "dope fiend" (Bonnie and Whitebread 1970). At this time, according to Courtwright's (1982) estimates, there were about 300,000 opiate addicts in the United States. But, he notes, the addict population was already changing. The medical profession had, by and large, abandoned its liberal use of opiates—imports of medicinal opiates declined dramatically during the first decade of the twentieth century—and the public mind, as well as that of much of the medical profession, came to associate heroin with urban vice and crime. In contrast with opiate addicts of the nineteenth century, opiate users of the twentieth century were increasingly male habitués of pool halls and bowling alleys, and denizens of the underworld, and they typically used heroin (Kinlock, Hanlon, and Nurco 1998; Acker 2002). As in the case of minority groups, this marginal population was an easy target of drug laws and drug law enforcement.

DRUG PROHIBITION

"Drug laws reflect the decision of some persons that other persons who wish to consume certain substances should not be permitted to act on their preferences. Nor should anyone be permitted to satisfy the desires of drug consumers by making and selling the prohibited drug.… [The] most important characteristic of the legal approach to drug use is that these consumptive and commercial activities are being regulated by force" (Barnett 1987: 73).

The commissioner of the Internal Revenue Service was placed in charge of upholding the Harrison Act, and in 1915, 162 collectors and agents of the Miscellaneous Division of the Internal Revenue Service were given the responsibility for enforcing drug laws. In 1919, the Narcotics Division was created within the Bureau of Prohibition with a staff of 170 agents and an appropriation of $270,000. The Narcotics Division, however, was tainted by its association with the notoriously inept and corrupt Prohibition Bureau and suffered from a corruption scandal of its own: "The public dissatisfaction intensified because of a scandal involving falsification of arrest records and charges relating to payoffs by, and collusion with, drug dealers" (PCOC 1986: 204). In response, in 1930 Congress removed drug enforcement from the Bureau of Prohibition and established the Federal Bureau of Narcotics (FBN) as a separate agency within the Department of the Treasury. "Although the FBN was primarily responsible for the enforcement of the Harrison Act and related drug laws, the task of preventing and interdicting the illegal importation and smuggling of drugs remained with the Bureau of Customs" (PCOC 1986: 205).

Case Law Results

In 1916, the Supreme Court ruled in favor of a physician (Dr. Moy) who had provided maintenance doses of morphine to an addict (*United States v. Jin Fuey Moy* 241 U.S. 394). In 1919, however, the Court ruled (*Webb v. United States* 249 U.S. 96) that a prescription for morphine issued to a habitual user not under a physician's care that was intended not to cure but to maintain the habit is not a prescription and thus violates the Harrison Act. However, private physicians found it impossible to handle the large drug clientele that was suddenly created; they could do nothing "more than sign prescriptions" (Duster 1970: 16).

In *United States v. Behrman* (258 U.S. 280, 289, 1922), the Court ruled that a physician was not entitled to prescribe large doses of proscribed drugs for self-administration even if the addict was under the physician's care. The Court stated: "Prescriptions in the regular course of practice did not include the indiscriminate doling out of narcotics in such quantity as charged in the indictments." In 1925 the Court limited the application of *Behrman* when it found that a physician who had prescribed small doses of drugs for the relief of an addict did not violate the Harrison Act (*Linder v. United States* 268 U.S. 5). In reversing the physician's conviction, the Court distinguished between *Linder* and excesses shown in the case of *Behrman*:

> *The enormous quantities of drugs ordered, considered in connection with the recipient's character, without explanation, seemed enough to show prohibited sales and to exclude the idea of bona fide professional activity. The opinion [in Behrman] cannot be accepted as authority for holding that a physician, who acts fide bona and according to fair medical standards, may never give an addict moderate amounts of drugs for self-administration in order to relieve conditions incident to addiction. Enforcement of the tax demands no such drastic rule, and if the Act had such scope it would certainly encounter grave constitutional guarantees.*

In fact, the powers of the Narcotics Division were clear and limited to the enforcement of registration and record-keeping regulations. "The large number of addicts who secured their drugs from physicians were excluded from the Division's jurisdiction. Furthermore, the public's attitude toward drug use," notes Donald Dickson (1977: 39), "had not much changed with the passage of the Act—there was some opposition to drug use, some support of it, and a great many who did not care one way or the other. The Harrison Act was actually passed with very little publicity or news coverage."

Richard Bonnie and Charles Whitebread (1970: 976) note the similarities between the temperance and antinarcotics movements: "Both were first directed against the evils of large scale use and only later against all use. Most of the rhetoric was the same: These euphoriants produced crime, pauperism and insanity." However, "the temperance movement was a matter of vigorous public debate; the anti-narcotics movement was not. Temperance legislation was the product of a highly organized nationwide lobby; narcotics legislation was largely ad hoc. Temperance legislation was designed to eradicate known evils resulting from alcohol use; narcotics legislation was largely anticipatory." In fact, notes H. Wayne Morgan (1981), comparisons between alcohol and opiates—until the nature of addiction became clear—were often favorable to opium. It was not public sentiment that led to antidrug legislation; nevertheless, the result of such legislation was an increasing public perception of the dangerousness of certain drugs (Bonnie and Whitehead 1970). As we will see, officials of the federal drug enforcement agency fanned this perception.

NARCOTIC CLINICS AND ENFORCEMENT

Writing in 1916, Pearce Bailey (1974: 173–174) noted that the passage of the act "spread dismay among the heroin takers":

> *They saw in advance the increased difficulty and expense of obtaining heroin as a result of this law; then the drug stores shut down, and the purveyors who sell heroin on the street corners and in doorways became terrified, and for a time illicit trade in the drug almost ceased. … Once the law was established the traffic was resumed, but under very different circumstances. The price of heroin soared [900 percent, and was sold in adulterated form]. This put it beyond the easy reach of the majority of adherents, most of whom do not earn more than twelve or fourteen dollars a week. Being no longer able to procure it with any money that they could lay their hands on honestly, many were forced to apply for treatment for illness brought about by result of arrest for violation of the law.*

Beginning in 1918, narcotics clinics opened in almost every major city. Information about them is sketchy (Duster 1970), and there is a great deal of controversy over their operations. While they were never very popular with the general public, most clinics were well run under medical supervision (Morgan 1981). While some clinics were guilty of a variety of abuses, the good ones enabled addicts to continue their normal lives without being drawn into the black market in drugs (Duster 1970). The troubled clinics, however, such as those in New York, where the number of patients overwhelmed the medical staff, generated a great deal of newspaper coverage, resulting in an outraged public.

Following World War I and the Bolshevik Revolution in Russia, xenophobia and prohibitionism began to sweep the nation. The United States severely restricted immigration, and alcohol and drug use was increasingly associated with an alien population. In 1922, federal narcotics agents closed the drug clinics and began to arrest physicians and pharmacists who provided drugs for maintenance. At issue was Section 8 of the Harrison Act, which permitted the possession of controlled substances if prescribed "in good faith" by a registered physician, dentist, or veterinarian in accord with "professional practice." The law did not define "good faith" or "professional practice." Under a policy developed by the federal narcotics agency, thousands of people, including many physicians—more than 25,000 between 1914 and 1938 (White 1998)—were charged with violations: "Whether conviction followed or not mattered little as the effects of press publicity dealing with what were supposedly willful violations of a beneficent law were most disastrous to those concerned" (Terry and Pellens 1928: 90). "Once a strict antidrug policy had been established, both the public's and policymakers' curiosity about the details of a drug's biological effects faded. Federal scientists also feared their research findings might conflict with official policies, so they avoided some areas of investigation" (Musto 1998: 62).

The medical profession withdrew from dispensing drugs to addicts, forcing them to look to illicit sources and giving rise to an enormous illegal business in drugs. People who were addicted to opium smoking eventually found their favorite drug unavailable—the bulky smoking opium was difficult to smuggle—and turned to the more readily available heroin that was prepared for intravenous use and would produce a more intense effect (Courtwright 1982). The criminal syndicates that resulted from Prohibition added heroin trafficking to their business portfolios. When Prohibition was repealed in 1933, profits from bootlegging disappeared accordingly, but drug trafficking remained as an important source of revenue for organized criminal groups. (Drug trafficking is discussed

in Chapter 9.) Law enforcement efforts against drugs have proven as ineffectual as efforts against alcohol during Prohibition, with similar problems of corruption.

The federal government shaped vague and conflicting court decisions into definitive pronouncements reflecting the drug enforcement agency's own version of its proper role: "American administrative regulations took on the force of ruling law" (Trebach 1982: 132). The drug agency also embarked on a vigorous campaign to convince the public and Congress of the dangers of drugs and thereby to justify its approach to the problem of drug use. According to Bonnie and Whitebread (1970: 990), the existence of a separate federal narcotics bureau "anxious to fulfill its role as crusader against the evils of narcotics" has been the single major factor in the legislative history of drug control in the United States since 1930.

The actions of the federal government toward drug use must be understood within the context of the times. The years immediately following World War I were characterized by pervasive attitudes of nationalism and nativism and by a fear of anarchy and communism. The Bolshevik Revolution in Russia, a police strike in Boston (see Russell 1975), and widespread labor unrest and violence were the backdrop for the infamous Palmer Raids of 1919, in which Attorney General A. Mitchel Palmer, disregarding a host of constitutional protections, ordered the arrest of thousands of "radicals." That same year the Prohibition Amendment was ratified, and soon legislation ended large-scale (legal) immigration. Drug addiction—morphinism/heroinism—was added to the un-American "isms" of alcoholism, anarchism, and communism (Musto 1973). In 1918, there were only 888 federal arrests for narcotics law violations; in 1920 there were 3,477. In 1925, the year the clinics were closed, there were 10,297 (Cloyd 1982). "During the 1920s and 1930s," notes Susan Speaker, "newspaper and magazine accounts of narcotics problems, and the propaganda of various anti-narcotics organizations used certain stock ideas and images to construct an intensely fearful public rhetoric about drugs. Authors routinely described drugs, users, and sellers as 'evil,' described sinister conspiracies to undermine American society and values, credited drugs with immense power to corrupt users, and called for complete eradication of the problem" (Speaker 2001: 1).

According to William White (1998: 113), Treasury Department opposition to prescribing drugs for addicts was based on a belief in the prevailing propaganda of the day with respect to alcohol treatment. "The Treasury Department opposed ambulatory treatment because, for many patients, it turned into sustained maintenance, and also because the remaining inebriate hospitals and asylums of the day were still boasting 95% success rates. After all, leaders of the Treasury Department argued, why should someone be maintained on morphine when all he or she had to do was to take the cure? It was through such misrepresentation of success rates that the inebriate asylums and private treatment sanitariums contributed inadvertently to the criminalization of narcotic addiction in the U.S."

In 1923 legislation was introduced to curtail the importation of opium for the manufacture of heroin, resulting in a ban on heroin in the United States. (In 1956, Congress declared all heroin to be contraband.) Among the few witnesses who testified before Congress, all supported the legislation. The AMA had already condemned the use of heroin by physicians, and the substance was described as the most dangerous of all habit-forming drugs, some witnesses arguing that the psychological effects of heroin use serve as a stimulus to crime. Much of the medical testimony, in light of what is now known about heroin, was erroneous, but the law won easy passage in 1924 (Musto 1973). A pamphlet published the same year by the prestigious Foreign Policy Association summarized contemporary thinking about heroin (cited in Trebach 1982: 48):

- It is unnecessary in the practice of medicine.
- It destroys all sense of moral responsibility.

- It is the drug of the criminal.
- It recruits its army among youths.
- The use of opiates, except for narrow medical purposes, was now thoroughly criminalized, both in law and in practice. The law defined "drug users" as criminals, and the public viewed heroin use as the behavior of a deviant criminal class.

The Uniform Drug Act

Until 1930, efforts against drugs were primarily federal. Only a few states had drug control statutes, and these were generally ineffective (Musto 1973). At the urging of federal authorities, many states enacted their own antidrug legislation. By 1931 every state restricted the sale of cocaine, and all but two restricted the sale of opiates. State statutes, however, were far from uniform. As early as 1927, this lack of uniformity, combined with the growing hysteria about dope fiends and criminality, resulted in several requests for a uniform state narcotics law. The diversity of state drug statutes was not an anachronism. The need for greater uniformity in state statutes was recognized in the first half of the nineteenth century, when a prominent New York attorney, David Dudley Field (1805–1894), campaigned for a uniform code of procedure for both civil and criminal matters. During the 1890s, the American Bar Association set up the National Conference of Commissioners on Uniform State Laws, whose efforts resulted in a variety of uniform codes that were adopted by virtually all jurisdictions (Abadinsky 2014).

The law defined "drug users" as criminals, and the public viewed heroin use as the behavior of a deviant criminal class.

A uniform drug act for the states was the goal of both the Committee on the Uniform Narcotic Act and representatives of the AMA because doctors wanted uniformity of legal obligations. Their first two drafts copied a 1927 New York statute that listed coca, opium, and cannabis products as habit-forming drugs to be regulated or prohibited. Because of opposition to its inclusion on the habit-forming list, cannabis was dropped from later drafts with a note indicating that each state was free to include or not to include cannabis in its own legislation without affecting the rest of the act. The final draft also used the 1927 New York statute as a model and included suggestions from the newly appointed commissioner of the FBN, Harry Anslinger. The National Conference of Commissioners on Uniform State Laws, to which each governor had appointed two representatives, adopted the draft overwhelmingly. By 1937 thirty-five states had enacted the Uniform Drug Act, and every state had enacted statutes relating to marijuana. Despite propagandizing efforts by the FBN, "The laws went unnoticed by legal commentators, the press and the public at large" (Bonnie and Whitebread 1970: 1034).

The lack of public concern is related to the demographics of drug use, which was concentrated in minority, lower-class areas, and the criminal subculture. Before the Harrison Act there was considerable use in rural areas; the South, where drugs often substituted for alcohol in dry areas, used more opiates than other parts of the country. After the Harrison Act addicts in rural areas were attended to quietly by sympathetic doctors. Heroin was heavily concentrated in urban areas of poverty. For example, during the early decades of the twentieth century, heroin use in New York was heaviest in the Jewish and Italian areas of the Lower East Side. As these two groups climbed the economic ladder and moved out, they were replaced by African Americans looking for affordable housing and this group then became the basis of the addict population (Helmer 1975). Demographics intensified the problem; African Americans had a higher birthrate than Jews and Italians, and an

extraordinary number of youngsters were 16 years old, the age of highest risk for addiction. After World War II, the white ethnic population became increasingly suburban and the inner city became increasingly black and Hispanic—a new vulnerable population in a drug-infested environment.

Pointing to the similarities between the prohibition against alcohol and that against other drugs, David Courtwright (1982: 144) asks why, since both reform efforts had ended in failure, did the public withdraw its support for one and increase its support of the other? "One factor (in addition to economic and political considerations) must have been that alcohol use was relatively widespread and cut across class lines. It seemed unreasonable for the government to deny a broad spectrum of otherwise normal persons access to drink. By 1930 opiate addiction, by contrast, was perceived to be concentrated in a small criminal subculture; it did not seem unreasonable for that same government to deny the morbid cravings of a deviant group."

World War II had a dramatic impact on the supply of heroin in the United States. The Japanese invasion of China interrupted supplies from that country, while the disruption of shipping routes by German submarines and attack battleships reduced the amount of heroin moving from Turkey to Marseilles to the United States. When the United States entered the war, security measures "designed to prevent infiltration of foreign spies and sabotage to naval installations made smuggling into the United States virtually impossible." As a result, "at the end of World War II, there was an excellent chance that heroin addiction could be eliminated in the United States" (McCoy 1972: 15). Obviously, this did not happen (the reasons will be discussed later) and "by the 1980s, an estimated 500,000 Americans used illicit opioids (mainly heroin), mostly poor young minority men and women in the inner cities" (Batki et al. 2005: 13).

The contemporary heroin market has moved well past its urban roots, becoming established in America's suburbs where adolescents frequently use it. Sources of the drug vary, but can be grouped into three broad categories:

1. Local suburban youngsters who search out heroin connections for personal use in inner-city locations. Eventually, they begin to bring additional quantities back home for sale. This phenomenon has been seen in suburban Nassau County, on New York's Long Island (Wolvier, Martino, and Bolger 2009). "The heroin being sold on Long Island is deadlier and cheaper than ever. A bag on the street costs about $6 or $7, cheaper than a pack of cigarettes. What makes the situation even more dangerous is the misconception among users that snorting or sniffing heroin, rather than injecting it, will not lead to addiction" ("Heroin on Long Island" 2009: 22).
2. Low-level urban dealers recognize suburban locations as both lucrative and less competitive markets they can more easily monopolize. This phenomenon has been experienced in suburbs across the Northeast (Calefati 2008).
3. Mexican drug cartels that dispatch small cells to take advantage of fertile suburban markets. The cells take orders over disposable mobile phones and use a system of dispatchers to deliver the drugs to various rendezvous points such as a shopping center parking lot. Cell members, often illegal immigrants, stay in one location for four or five months and are then rotated as replacements arrive. This has been experienced in suburban Ohio locations (Archibold 2009). Distributors in New Jersey are targeting customers in smaller towns and rural areas to gain market share. Heroin availability has increased in Upstate New York, which has led to a corresponding increase

in the number of urban and suburban youths from outlying rural counties traveling to Albany, Erie, Monroe, and Onondaga counties to obtain the drug for personal use (National Drug Intelligence Center 2009f).

The source of most opium cultivated for medical use is the Australian island state of Tasmania. The size of West Virginia, Tasmania grows about 85 percent of the world's thebaine, an opium poppy extract used in products such as oxycontin and oxycodone (Bradsher 2014).

COCAINE

Cocaine is found in significant quantities only in the leaves of two species of coca shrub that are indigenous to certain sections of South America, though they have been grown elsewhere. "For over 4,000 years among the native Andean population the coca leaf has been used in ancient rituals and for everyday gift giving. Holding spiritual, economic, and cultural significance, coca is seen as an important medium for social integration and human solidarity in the face of adverse conditions" (Wheat and Green 1999: 42). To the Incas, the plant was of divine origin and was reserved for those who believed themselves descendants of the gods. In Bolivia it is drunk as *mate* (coca tea), and the leaves are chewed for hours by farmers and miners along with an alkaloid that helps to release the active ingredients. "The result is similar to a prolonged caffeine or tobacco buzz. But it is more than that. It improves stamina, is a sacred symbol central to community life and provides essential nutrients" (Wheat and Green 1999: 43).

European experience with chewing coca coincided with Spanish exploration of the New World. While the early Spanish explorers, obsessed with gold, referred to coca leaf chewing with scorn, later reports about the effects of coca on Indians were more enthusiastic. Nevertheless, the chewing of coca leaves was not adopted by Europeans until the nineteenth century (Grinspoon and Bakalar 1976). A "mixture of ignorance and moral hauteur played an important role in the long delay between the time Europeans first became acquainted with cocaine—in the form of coca—and the time they began to use it" (Ashley 1975: 3). The coca leaves tasted bitter and were favored by pagans—Peruvian Indians—"an obviously inferior lot who had allowed their great Inca Empire to be conquered by Pizarro and fewer than two hundred Spaniards." Early records indicate that the effects of coca—stamina and energy—were ascribed not to the drug but to a pact the Indians had made with the devil or simply to delusion—the Indian is sustained by the *belief* that chewing coca gives him extra strength.

Nineteenth Century

Alkaloidal cocaine was isolated from the coca leaf by German scientists in the decade before the American Civil War, and the German chemical manufacturer Merck began to produce small amounts (Karch 1998). Scientists experimenting with the substance noted that it showed promise as a local anesthetic and had an effect opposite that caused by morphine. Indeed, at first cocaine was used to treat morphine addiction, but the result was often a morphine addict who was also dependent on cocaine (Van Dyke and Byck 1982). Enthusiasm for cocaine spread across the United States, and by the late 1880s, a feel-good pharmacology based on the coca plant and its derivative cocaine emerged, as the substance was hawked for everything from headaches to hysteria. "Catarrh powders for sinus trouble and headaches—a few were nearly pure cocaine—introduced the concept of snorting" (Gomez 1984: 58). Patent medicines frequently contained significant amounts of cocaine.

One very popular product was the coca wine *Vin Mariani*, which contained two ounces of fresh coca leaves in a pint of Bordeaux wine; another, *Peruvian Wine of Coca*, was available for $1 a bottle through the 1902 Sears, Roebuck catalog. The most famous beverage containing coca, however, was first bottled in 1894, and an advertisement for Coca-Cola in *Scientific American* in 1906 publicized the use of coca as an important tonic in this "healthful drink" (May 1988: 29). A 1908 government report listed more than forty brands of soft drinks containing cocaine (Helmer 1975). In contrast to the patent medicines, however, these beverages, including wine and Coca-Cola, contained only small, typically trivial, amounts of cocaine (Karch 1998).

In 1884, Sigmund Freud began using cocaine and soon afterward began to treat his friend Ernst von Fleischl-Marxow, who had become a morphine addict, with cocaine. The following year, von Fleischl-Marxow suffered from toxic psychosis as a result of taking increasing amounts of cocaine by subcutaneous injection, and Freud wrote that the misuse of the substance had hastened his friend's death. Although Freud continued the recreational use of cocaine as late as 1895, his enthusiasm for its therapeutic value waned (Byck 1974). Influenced by the writings of Sigmund Freud on cocaine, William Stewart Halstead, surgeon-in-chief at Johns Hopkins Hospital and the "father of American surgery," began experimenting with the substance in 1884. When he died in 1922 at age 70, Dr. Halstead was still addicted to cocaine despite numerous attempts at curing himself (White 1998).

ACCORDING TO DR. FREUD

"A few minutes after taking cocaine, one experiences a sudden exhilaration and feeling of lightness. One feels a certain furriness on the lips and palate, followed by a feeling of warmth in the same areas; if one now drinks cold water, it feels warm on the lips and cold in the throat … The psychic effect of *cocaïnum muriaticum* in doses of 0.05–0.10g consists of exhilaration and lasting euphoria. … One senses an increase of self-control and feels more vigorous and more capable of work" Sigmund Freud, *Über Coca* (1884: 289–290).

After the flush of enthusiasm for cocaine in the 1880s, its direct use declined. Cocaine continued to be used in a variety of potions and tonics, but unlike morphine and heroin, it did not develop a separate appeal (Morgan 1981). Indeed, it gained a reputation for inducing bizarre and unpredictable behavior.

Cocaine in the Twentieth Century

After the turn of the century, cocaine, like heroin, became identified with the urban underworld and, in the South, with African Americans. "As with Chinese opium, southern blacks became a target for class conflict, and drug use became one point of tension in this larger sociopolitical struggle" (Cloyd 1982: 35). The campaign against cocaine took on bizarre aspects aimed at winning support for antidrug legislation among Southern politicians, who traditionally resisted federal efforts that interfered with their concept of states' rights. Without any research support, a spate of articles alleged widespread use of cocaine by African Americans, often associating such use with violence and the rape of white women (Helmer 1975). Ultimately, notes Jerald Cloyd (1982: 54), "Southerners were more afraid