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The Early Criminalization of Narcotic Addiction

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NOTE: The original 1,000+ page manuscript for *Slaying the Dragon: The History of Addiction Treatment and Recovery in America* had to be cut by more than half before its first publication in 1998. This is an edited excerpt that was deleted from the original manuscript.

The Philippine Influence

The Philippine Islands (along with Puerto Rico and Guam) came under U.S. rule in 1898 after America's victory in the Spanish American War. Concerned with the possibility of unrest on the islands, Congress passed a 1902 statue that prohibited U.S. traders from delivering guns, alcohol, or opium to the Pacific Islands. A 1903 report noting the use of opium by American soldiers stationed in the Philippines led to a commission investigation. That investigation concluded that opium use was not as widespread in the Philippines as it was in other parts of the Orient, but suggested that the practice might spread unless efforts were made to suppress it. The commission recommended that the opium traffic be phased out over a three-year period. William Howard Taft, the appointed Civilian Governor of the Philippines, recommended that an opium monopoly be established, with its revenues used for an educational campaign to suppress its use. President Theodore Roosevelt rejected both suggestions. In 1905, Congress banned all non-medical use of opium by native Filipinos and prescribed a three-year period for gradual reduction of opium use by non-Filipinos on the Islands. David Musto (1987) describes the drug-dispensing clinics set up in the Philippines in 1908 to wean addicts from opium as the first narcotic clinics sanctioned and operated by the U.S. Government. Growing concern over opium smuggling in the Philippines—and intensified efforts by the Chinese to suppress opium addiction—led to the call for a regional conference to discuss the opium problem (Kramer, 1972; Musto, 1973; Scott, 1969).

The Chinese Influence

At the turn of the century, America was quite interested in improving relations and opening up trade with China, but many factors compromised this position. In earlier years Americans had profited from opium trading with China. Mistreatment of Chinese

in the Western States was also well known in China. And the most common result of the U.S.-initiated prohibition of opium in the Philippines was the arrest of Chinese opium users who lived on the Islands.

At the time of the Shanghai Opium Convention (1909), China was attempting to eliminate the opium problem that had been imposed on her by military force in two opium wars. As America representatives set out for the Convention, they did so with a desire to improve American relations with China by demonstrating U.S. willingness to play a responsible role in international narcotics control. The fact that the U.S. had no national anti-narcotics legislation made it harder to project a strong anti-narcotics image. U.S. involvement in the Philippines, and our goal of building a relationship with China, led to political pressure for federal anti-drug legislation (Platt, 1986).

The Shanghai Opium Convention and the Hague Conferences of 1912-1913

The Right Reverend Charles H. Brent, Protestant Episcopal Bishop of the Philippines and a member of the investigating commission that studied opium use in the Philippines, led the call for an international conference—the International Opium Commission—held in Shanghai in 1909. The American delegates, led by Brent and the State Department's opium commissioner, Dr. Hamilton Wright, spearheaded a resolution proposing the international prohibition of opium. While the Convention was in session, Congress—to show America's good faith to the Chinese—passed an act that banned the importation of opium and opium products into the United States for any purposes other than medical use. Though a formal treaty was not agreed upon in Shanghai, the American leaders returned determined to continue their push for additional federal anti-drug legislation (Payne, 1931).

In 1912, a follow-up meeting to the Shanghai Convention was held in The Hague, Netherlands. A multi-lateral treaty was negotiated at this meeting, calling for the international suppression of opium. The United States delegation played an aggressive role in pushing for the most extreme limits on opium production and distribution. An observer of the meeting, J.M. Scott, described the American delegation as "direct, idealistic, uncompromising, and unpopular." Participating countries agreed to grow and trade only enough opium for legitimate medical use. On his return, Wright worked tirelessly to draft federal anti-narcotics legislation and see it through Congress.

Reviewing this period, John Kramer suggests that The Hague Convention was organized "so that the Harrison Act could be passed" (Kramer, 1972). David Musto, who has written the definitive history of this era of narcotics control, suggests that figures like Brent and Hamilton Wright created an international framework that would require us to develop domestic policies in order to avoid international embarrassment (Musto, 1973).

In order to throw the federal government into the middle of the stigmatized subject of drug addiction, they had to convince the public and members of Congress that this problem was widespread enough to deserve serious attention. This effort required that they estimate the number of addicts in the United States.

How Many Addicts? The Manipulation of Numbers

Estimating the number of addicts has always been the privilege of the addiction expert and the politician. As early as 1868, Horace Day, in his treatise The Opium Habit, tried to raise public alarm with his estimate that there were between 80,000 and 1,000,000 American drug addicts.

It is clear that the policy shift toward criminalizing addiction was based on public perception of the problem rather than on precise, factual documentation of changes in drug use or the social costs associated with such use. This public perception was shaped by estimates of the extent of drug addiction, estimates that ranged from 100,000 to 1,000,000. Many factors led to wildly differing views of the nature and extent

of drug use, and most of those factors served to exaggerate the numbers of users. In their call for legislative action, the moral reformers painted the picture of a raging drug epidemic, giving the public and political leaders ridiculous estimates of the scope of the problem. Many estimates were based on the numbers of people reported to have been treated at various inebriate asylums throughout the country—reports often inflated for marketing purposes. Advertisements for the asylums often claimed to have treated anywhere from 30,000 to 100,000 addicts. (Dr. Leslie Keeley boasted that the Keeley Institutes had treated more than 500,000 alcohol and narcotic inebriates.)

Autobiographical accounts of addiction also tended to give the impression that nearly everyone was experimenting with these drugs—a contention clearly meant to justify the fact that the authors had ended up in such a condition. Newspaper accounts of an addiction epidemic—the more sensational the better—were simply good business.

Courtwright reviewed the official estimates of addiction in the U.S. made by law enforcement authorities during this period. He noted that these figures were shaded upward in order to justify stricter laws or to gain wider bureaucratic influence. Courtwright also noted that some figures were later shaded downward to demonstrate the effectiveness of the laws and enforcement efforts (Courtwright, 1982). Politicians and freelance reformers used claims of a drug epidemic to enhance their own careers. Except for the interests of general practice physicians and pharmacists—who risked both blame for contributing to the addiction problem and loss of income if their services to addicts were limited—it seems that everyone's interests were served by exaggerating the extent of drug use.

What is most surprising is that legislative activity in the early 20th century—and in the years that would follow—would be based on "educated guesses" made by people whose personal and institutional self-interests were directly affected by the public's beliefs about the extent of drug use. The conclusion David Courtwright came to in his study of early American narcotic control policies is that American narcotic laws were "...passed, interpreted, and defended on the basis of misleading, even fraudulent information" (Courtwright, 1982).

There is no question that opiate use was on the increase in the 19th century. After reviewing all available 19th-century surveys of addiction, Bonnie and Whitebread (1970) concluded that, by the turn of the century, between one-quarter and one-half million Americans—approximately one percent of the population— were addicted to narcotics.

What is not clear is how far future narcotic use would have evolved if the federal anti-drug laws had not been passed. Investigators such as Musto, Courtwright, and Morgan independently concluded that opium imports peaked and fell after 1896, and that in the early years of the 20th century—even before the federal anti-drug legislation was passed—opiate addiction was on the decline (Musto, 1973; Courtwright, 1982; Morgan, 1974).

Joseph Spillane's study of early American cocaine use suggests that the use of that drug had also begun to decline in the years before the Harrison Act. He attributes this reduction to the introduction of alternatives to cocaine in American medicine and to the medical community's growing awareness of the potential of cocaine misuse (Spillane, 1994).

These reinterpretations of the extent of early 20th-century drug abuse raise an interesting possibility. The United States may have stepped in to criminalize addiction just when addiction was already declining in response to other measures. Addicted Civil War veterans—and others addicted in the heyday of the morphine-filled syringe—were dying of old age as the new century unfolded. New cases of physician-caused addiction were declining. This was the result of medical education, and of medical breakthroughs that prevented disorders that, like typhoid fever, had traditionally been treated with narcotics. Aspirin and other new non-addicting pain killers also came into

widespread use as a replacement for narcotics. Truth-in-labeling laws, prescription laws, and public education were also working together to limit opiate use.

If the use of these drugs was already on the decline, did criminalization lower their levels of use even further? Or is it possible that the criminalization of addiction in America actually led to an increase in addiction? Although there is some evidence that America's drug problem was already diminishing, the federal narcotic laws of the early 20th Century—like those of the late 20th Century—were shaped not by numbers, but by dramatic stories and the powerful emotions they raised in the American public.

Municipal and State Anti-Drug Legislation

At the end of the 19th century, municipal and state policy makers became more and more aware of two patterns of drug use. First there was the growing recognition that vulnerable people—people in physical or psychological pain—were becoming addicted to narcotics because of incompetent medical treatment and an unscrupulous patent medicine industry. Second was the realization that the use of drugs purely for pleasure was increasing. This perception of narcotics both as harmful medicines and as a new form of vice led to calls for state anti-drug laws. It also led to patterns of indirect law enforcement—in which known drug users were harassed through targeted enforcement of building codes and vagrancy laws—long before specific statues were passed controlling the possession and sale of intoxicating drugs (Baumohl, 1992).

At the state and municipal levels, control of narcotics and dangerous drugs was inconsistent. A few states passed early narcotics control statutes. Illinois, for example, passed an 1853 law requiring that the ingredients be printed on the packages of all drugs sold at the retail level. California passed an 1862 statute criminalizing "the administration of drugs with intent to facilitate commission of a felony" (Wilner and Kassebaum, 1965, p. 21). This was followed by a brief flurry of activity in Nevada (1877) and Oregon (1877) that was part of the mid-'70s anti-opium campaign on the West Coast. Illinois passed an 1881 Pharmacy Act that controlled by whom, to whom, and under what conditions narcotics, chloral hydrate, and cocaine could be distributed. That law prohibited druggists from selling opium, morphine, and cocaine to those less than 15 years of age or to others who wanted the drugs for anything other than "legitimate" purposes. The penalty for physicians and druggists who broke the law was a fine of $5, along with the possibility that their licenses to practice might be revoked (Leighton & Bargiel, 1975; Kolb, 1962; Griffin, 1977).

The most significant movement in the creation of state anti-drug laws took place the years 1897 to 1912—a span of 15 years in which all but one state passed anti-drug legislation. Many state laws were modeled on the early 20th-century prescription laws passed by Oregon, Kentucky, Tennessee, and the District of Columbia. Most early state laws to address drug misuse allowed small amounts of narcotics and other drugs in patent medicines, prohibited higher dosages except through physician prescription and pharmacist distribution, required a license to distribute narcotics or dangerous drugs, prohibited the refilling of narcotic prescriptions, and required that physicians and pharmacists document their prescription and dispensing of narcotics and other dangerous drugs (Platt, 1986).

Some states sought to control the addicts as well as the drugs. A 1913 Tennessee law required that addicts who wanted to refill narcotics prescriptions had to be registered as addicts with the state. This act stopped short of full prohibition, instead providing a way for confirmed addicts to be medically maintained on narcotics. In 1914, Tennessee had 2,370 registered addicts—90% white and two thirds women. A New York statute sought to encourage addicts to enter sanitaria by setting a three-week limit on the length of time physicians could prescribe narcotics (Brown, 1915; Platt, 1986).

As America was about to pass its landmark federal drug control legislation,

many states had already passed laws restricting the use of narcotics and cocaine. This is an important point often missed in the modern retelling of America's drug-control history. Many texts read as if the federal legislation passed in 1914 was the first of its kind, taking by surprise a country that had little understanding of its actual intent. But the great number of municipal and state drug-control activities we have just reviewed suggests that the Harrison Act was the culmination of this local and state activity, rather than the beginning of American drug-enforcement activity.

There were many reasons for this federal action: Not all states had drug-control laws, the quality of the existing state laws varied considerably, and state enforcement of these laws was at best inconsistent. The Harrison Act is also often portrayed as a piece of reactionary legislation—a step backwards for the nation. But the Harrison Tax Act was in the mainstream of a broad, progressive reform movement. Until the passage of the Harrison Act in 1914, local and state laws provided the support and the model for federal drug control. After 1914, the federal government itself began to emerge as the dominant influence on state and local drug control efforts. While the Harrison Act was in many ways a culmination of state and local drug control campaigns, the administrative and legal interpretations of this act would bring consequences that went far beyond what any local or state measures had achieved.

The Lobbying of Physicians and Pharmacists

Out of concern for the public welfare and in the interest of self-protection, physicians and pharmacists actively participated in shaping turn-of-the-century state and federal drug-control laws. In 1903 the American Pharmaceutical Association's Committee on the Acquirement of the Drug Habit issued a report that called for both national and state control (but not prohibition) of narcotic drugs. One of the ways in which doctors and pharmacists influenced this legislation was by developing model drug legislation. James Beal, a lawyer and pharmacist working on behalf of the American Pharmaceutical Association's Committee on Acquirement of the Drug Habit, drew up a model statue that was highly influential in helping states craft their prescription laws.

Physicians and pharmacists saw the agitation for drug-control legislation as an opportunity to strengthen their professional prestige and build a monopoly on access to psychoactive drugs. Doctors and pharmacists lobbied for their role as gatekeepers of narcotic drugs—and at the same time lobbied against what they considered excessive penalties and demands for record keeping (Platt, 1986).

The Public Campaign for Drug Control

While the portrayal of certain classes of drug users as "dope fiends" littered the early 20th-century popular press, literature, and cinema, grassroots public agitation was also needed to complete the drive for state and federal drug-control laws. Advocacy came from key civic groups and from two unlikely figures: a New York Socialite and a Spanish American War hero.

The first social group that took on the drug issue was the Anti-Narcotics Department of the Women's Christian Temperance Union (WCTU), a department founded within the WCTU in the 1890s. This department began what would be a sustained drive to heighten public awareness of drugs of abuse through a media and school campaign. This campaign picked up steam from periodic bursts of parallel activity by such groups as the Loyal Order of the Moose, the Kiwanis, the Knights of Columbus, and other national and local civic organizations. New York City's Committee of Fourteen launched highly publicized investigations into the links between cocaine use and prostitution and called for legislative control of cocaine. But perhaps the most effective community organization demanding drug control legislation was The New England Watch and Ward Society.

The New England Watch and Ward Society ran a public education campaign that portrayed narcotic addiction as a highly infectious disease. The Society proposed the long-term institutionalization of addicts—a proposal that they suggested would eliminate the contagious “carriers” of the drug habit and destroy the source of income for illicit peddlers (Jaffe, 1976, p. 100-114). Members of the New England Watch and Ward Society were so committed to drug eradication that they actually served as amateur enforcement officers and boasted of the number of drug sellers who had been sentenced to the House of Corrections as a result of their efforts. Their 1912 pamphlet "The Dope Evil" is filled with stories of young women being seduced into opium addiction due to their love of the food in Chinese restaurants, and of young men lured into cocaine use in houses of prostitution (Chase, 1912). All of these groups generated heightened press coverage of the addiction problem. Into this milieu of press coverage and public concern about addiction entered one of New York’s most prominent women, Mrs. Ann Vanderbilt (Jaffe, 1976).

The upper crust of New York society competed in many areas, including their leadership of popular reform efforts. It was in this context that Ann Vanderbilt found herself in direct competition with her husband's first wife, Ann Harriman Sands, who was gaining much attention for her leadership in the suffrage movement. Seeking similar recognition, Mrs. Vanderbilt launched a crusade against drugs in New York City. With unlimited funds and time, Mrs. Vanderbilt waged a relentless campaign for anti-narcotics legislation. She launched publicity campaigns, led marches down Fifth Avenue, and made pleas to all the right politicians. She warned New York society of the danger that 1.5 million crazed drug fiends would come spilling out of Harlem and the Bronx. She warned the citizenry about enemy agents who were spreading heroin-laced candy on school grounds. All of this public speaking was only a prelude to her role in passing New York’s Town-Boylan Act—the most restrictive anti-narcotics law in the U.S. and a law that was held up as a model for potential federal action.

The Town-Boylan Act required prescriptions for medicines containing more than a certain amount of narcotics, prohibited refills, required that pharmacists verify prescriptions for orders above a designated amount, required documentation of all narcotic transactions, and included provisions for the legal commitment of addicts to institutions licensed to treat addiction. Especially significant was the fact that the Act provided criminal penalties for possession of narcotics without a prescription.

While the option of mandated treatment existed under the Town-Boylan Act, that option was limited in practice by the small number of treatment facilities available. As it passed the law, the New York legislature called upon hospitals to develop programs for the addicts who, no longer able to maintain their drug supplies, would be coming forward in search of a cure (Glatt, 1986).

Ann Vanderbilt’s New York campaign drew national publicity and added fuel to the drive for a policy of strict federal drug control. It also greased the path for federal legislation by creating a legal precedent for criminal penalties for all non-medical sales and possession of narcotics and cocaine. The New York media campaign relentlessly linked cocaine use with African Americans, and morphine and heroin addiction with young immigrant gangs and an immigrant criminal underworld.

Another dynamic force for strong federal action against drugs was Captain Richard Hobson, a highly decorated veteran of the Spanish American War, who served as a human bridge between the alcohol temperance and prohibition movements and the anti-narcotics movement. He is a singular figure who played a highly visible role in both the passage of the Eighteenth Amendment and the passage of the most important piece of anti-drug legislation in American history. After serving as a Congressman from Alabama between 1906 and 1915, Hobson made a career as an anti-alcohol and anti-drug campaigner.

Hobson first launched a crusade against alcohol that made him one of the highest-paid speakers on America's lecture circuit. He organized the American Alcohol Education Association, the International Narcotic Education Association, the World Conference on Narcotic Education, and the World Narcotic Defense Organization (also known as the World Narcotic Association and the Narcotic Defense Foundation) as platforms for his campaigns. He was a major force in establishing and honoring a national Narcotic Education Week. He claimed that more than 21,000 clubs and 400 radio stations hosted special programs observing this Week (Hobson, 1928). Hobson reached a large audience in the 1920s through radio, through the journal Narcotic Education, and through repeated presentations to such civic clubs as the Moose, Kiwanis, and Lions (Speaker, 1996). Hobson's pronouncements went beyond the normal racism of the anti-drug propagandists. He compared narcotics to "invading hoards from Asia and Africa," declared that alcohol and drug addictions were more contagious and less curable than leprosy, and suggested that the overwhelming failure to achieve a permanent cure justified calling addicts "The Living Dead" (Hobson, 1928, p.52). He even suggested that one could become addicted by touching heroin and warned women to have their face powder checked for its presence—as if it would be placed there by some predatory dope dealer (Musto, 1981b). In presenting his theory of alcohol's contribution to racial degeneracy, he reported that Blacks became cannibalistic and Indians became violent "savages" when alcohol "reached the top of the brain." He was responsible for sparking the interest of many social clubs in the drug problem and persuading the government to establish a "narcotic education week." His book *Drug Addiction—A Malignant Racial Cancer* exploits every conceivable racial stereotype in order to build the case that vulnerable White youth were in danger of being "contaminated" by the spread of addiction from the Yellow and Black races (Hobson, 1933; Epstein, 1977, p. 25).

Drug prohibition campaigns often involve a manipulation of public fear. Captain Richard Hobson, a master at such manipulation, played a contributing role in the alcohol and drug prohibition campaigns of the early 20th century. Hobson's advocacy of radical solutions to the drug abuse problem—such as the extermination of all addicts—made mere criminalization look reasonable and moderate by comparison.

At the same time, public campaigns against widespread drug use in the community were matched by a growing concern about drug use by American soldiers.

Drugs in the Military

The first reports of heroin use by American soldiers were noted during the years 1912 and 1913. Soldiers called the drug "happy dust" and inhaled it through their noses. In 1913, Captain R.M. Blanchard of the U.S. Army Medical Corps reported treating a heroin-addicted soldier. The investigation of this soldier led to his "dope book," which listed about 30 other heroin using soldiers stationed at Fort Strong outside Boston, Massachusetts. The Army's response was to discharge any known drug users and to prevent their future re-entry into the military (Blanchard, 1913). It was during this same period that lurid accounts appeared of "thousands" of New York City draftees being rejected because of heroin addiction (Musto, 1974). The drive toward federal narcotics control that led to the Harrison Act was said to be necessary to stop rising drug addiction in the American military (McWilliams, 1991).

A Confluence of Events and Interests

Momentum was building for federal controls on American consumption of alcohol, narcotics, and other psychoactive drugs. No single force created this shift in federal policy. Instead, it was a combination of events and interests that all came together on the side of federal action. There were the international interests involving the

Philippines and China. There were the institutional interests of physicians and pharmacists. There was the discovery by those controlling the print and visual media that sensationalist accounts of drug addiction brought in profits. There were the public campaigns of people like Vanderbilt and Hobson. There was the public perception of the threat posed by what seemed to be an imminent epidemic of drug addiction. There was the inconsistent quality and enforcement of state drug-control legislation. There were rumors of growing drug use among U.S. soldiers. No single one of these factors would have been enough to push the federal government into an entirely new area of responsibility. But these combined forces did just that. The central point in the history of America's response to drug addiction was the passage of the Harrison Tax Act of 1914 and the interpretations and enforcement of this law.

The Anti-Narcotic (Harrison) Act and the Criminalization of Addiction

Until the early 20th century, federal involvement in the problem of drug addiction had been limited by the clear lines between federal and state authority. There were two primary ways the federal government could intervene in domestic affairs: by regulating interstate commerce and by levying taxes. The broader power to deal with social problems was left to the states. The earliest federal involvement in the narcotics issue centered on the tariff acts, which required a tax on imported opium as early as 1846. In the laws of 1857, 1861, and 1864, tariffs were increased from $1 to $2, then to $2.50 per pound of imported opium. In 1870, as anti-Chinese sentiment was intensifying in the West, the general tariff on opium was reduced to $1 per pound, while the tax on smoking opium was set at $6 per pound. Taxes on smoking opium were later raised to $10 (1883), then $12 (1890), while the tax on crude opium was dropped in 1894. These early acts were not public-health initiatives; they were revenue initiatives.

Early efforts to pass national anti-drug legislation date back to unsuccessful attempts in 1880 and 1884 to pass opium-control statues in Congress (Kandall, 1996). The first Federal act that specifically noted concern about the abuse of narcotics was an 1886 act that went by the lengthy title: "An Act to Provide for the Study of Alcoholic Drinks and Narcotics, and Their Effects Upon the Human System, in Public Schools of Territories and the District of Columbia, and in Military Schools and Naval Academies and Indian and Colored Schools in the Territories of the United States" (Payne, 1931, p.156). No decisive action on narcotics control came until the early 20th century.

The earlier-noted anti-opium measures governing the Philippines and the 1906 Pure Food and Drug act—as well as the 1906 District of Columbia Pharmacy Act, which regulated non-medical use of cocaine and opiates and prohibited narcotic maintenance by physicians—all served as a warm-up to the federal criminalization of addiction. In 1909 Congress passed a law prohibiting the importation of smoking opium. The impetus for this law came from momentum generated by state and local anti-opium ordinances that targeted the Chinese opium dens, and from Christian missionary societies wishing to strengthen their foreign anti-opium campaigns (aimed at protecting the "uncivilized races") by setting a moral example at home (McNamara, 1973, p.16) . Support was growing for the national control of the non-medical use of cocaine and opiates. In 1910 David Foster of Vermont introduced a bill into the House of Representatives that called for just such control, but the bill was defeated by lobbying from those who opposed the taxation, those who opposed the record-keeping provisions, and those who were worried about the loss of revenue that the act might create.

In January, 1914, as a prelude to the more restrictive legislation that would follow, Congress effectively banned the manufacture of smoking opium. A license fee for opium manufacture was set at $100,000, and a tax was levied on smoking opium at $100 per pound produced (Kramer, 1971). Representative Francis Harrison of New York introduced the Anti-Narcotic Act

into the House of Representatives on December 14, 1914. To avoid constitutional challenge of the federal government's right to prohibit the possession or sale of narcotics, the proposed law was framed as a revenue act. The bill placed a tax on the distribution of cocaine and narcotics. One needed a license to pay the tax, and licenses were issued only to physicians. Addicts who had been able to buy their drugs from a wide variety of legal sources could, under the proposed law, legally receive drugs only from a registered physician. Possession of drugs without a prescription would be a criminal offense. The bill further required that the step-by-step movement of drugs from drug companies to pharmacies to physicians be thoroughly documented.

Two new circumstances increased the likelihood that this bill would not be defeated as the Foster Bill had in 1910-11. First, in the new bill the concerns of the medical and pharmaceutical industries were worked out in compromises. The American Medical Association, the American Pharmaceutical Association, and the State and Treasury Departments lobbied successfully for refinements in the proposed law. Their efforts resulted in a number of changes to the original version. Cannabis and chloral hydrate were deleted from the legislation as a concession to the medical profession. The heroin content in a medicine that could be exempt from the law was raised from 1/12 of a grain to 1/8 of a grain. Registration and recording procedures were simplified (Platt, 1986).

The second circumstance was a new set of rationales presented in support of the new legislation. In his presentations in support of the bill, Dr. Hamilton Wright now emphasized the growing role of drugs as a source of social disorder. His inflammatory stories of attacks on whites by cocaine-crazed blacks struck a responsive chord with the Southern Democrats who controlled the House of Representatives. In this light, it should not be surprising that the drug targeted for the most severe restrictions was cocaine. In its final form the Harrison Act prohibited the use of cocaine in patent medicines and required that cocaine be obtained only through physician prescription (Musto, 1987, 1991).

President Woodrow Wilson signed the Harrison Anti-Narcotic Act in December 1914, and the new law took effect March 15, 1915. The response was immediate—124,000 physicians, 47,000 pharmacists, and 1,600 drug companies registered to possess and distribute drugs legally under the Harrison Act. There was nothing in the language of the Act that signaled government intent to deprive addicts of legal access to narcotics—nothing that would imply the government's intent to restrict a physician's right to prescribe to addicts. This would soon change.

Newspapers across America speculated on the likely effects of the new law. Newspapers in Springfield and Decatur, Illinois, for example, estimated the number of addicts in their cities, noted that some were people one would never suspect of being addicts, and predicted that the new law would "unmask some of these (people) and show them to the world as fiends" (Law Hit 'Dope Fiends' Decatur Herald and Review, September 4, 1988)

The Harrison Act was characterized by what Anthony Saper has called "simple construction and complex interpretation" (Saper, 1974, p. 186). Its simple character involved three primary provisions: 1) anyone involved in the production and distribution of narcotics had to maintain records and be registered with the government, 2) anyone registered was required to pay a tax, and 3) retail sales of narcotics required a physician’s prescription and were to be used only to fulfill legitimate medical needs. The interpretations and consequences of the Harrison Act went far beyond these three provisions (Saper, 1974).

The intent of the Harrison Act was to eliminate the non-medical use of opiates, cocaine, and chloral hydrate by stopping their over-the-counter sale and by controlling the prescribing practices of physicians; this would eliminate general access to these drugs. The chosen means of control was a tax act that imposed taxes on licensed vendors and restriction of people who could get a license to purchase and sell these

drugs. Why was an anti-drug measure put in place as a piece of tax legislation? The answer is that Congress in 1914 was unsure of its constitutional authority to venture into this area. While its authority to regulate interstate drug traffic and control the transactions between physicians and their patients was in doubt, its ability to levy taxes was unquestionable (McNamara, 1973).

Few members of Congress voting to pass the Harrison Act could have envisioned its eventual impact. The criminalization of drug addiction in the United States came—not as a result of social consensus or of the legislative intent embodied in the Act—but by administrative decree. Many critics of 20th-century narcotic control policies actually think the Harrison Act, as written, was a reasonable control strategy. The criminalization of those already addicted was not the goal of the Harrison Act. This twist unfolded according to interpretations and actions taken by the Department of Treasury, the federal agency responsible for enforcing the Act (Kramer, 1972).

Arnold Jaffe's treatise on narcotic reforms during the Progressive era, perhaps more than any study, underscores the fact that the bureaucratic institution responsible for enforcement of the Harrison Act often pursued independent courses of action quite different from the policies and intent of the legislature (Jaffe, 1976). The key actors in this stage of our story include those responsible for the enforcement of the Harrison Act: Colonel Levi Nutt, the head of the Narcotics Division of the newly created National Prohibition Administration of the Internal Revenue Bureau, and his staff of 170 agents.

Through a series of administrative regulations formally issued by the Department of Treasury and backed up by a number of Supreme Court Decisions, physicians were prohibited from maintaining addicts on their usual dose of narcotics. For the first time in American history, a person addicted to narcotics had no legal way to gain access to narcotics. By administrative decree, America's hidden addicts had been transformed from sympathetic victims and patients to criminals.

We have seen how a wide variety of forces led to the call for a stronger, more centralized (federal) control strategy to manage psychoactive drug use in America. We have seen that the Harrison Act did not outlaw cocaine and narcotics, but instead named physicians as the cultural gatekeepers responsible for deciding who would receive these drugs and the conditions under which the drugs would be legally provided. There was nothing in the language of the Harrison Act that even touched on addicts and addiction, nothing that implied administrative control over physicians' medical practice or choice of patients. And nothing in the Act even hinted that narcotics and cocaine—as well as the condition of addiction—was about to be criminalized. In other words, what started out on paper as a medicalization of the management of opiates and other drugs was transformed into a policy of criminalization. How did America move from the language of the Harrison Act to interpretations of this law that would virtually turn addict-patients—and many of their physicians—into criminals?

In later studies of that time, the Treasury Department officials who set forth these regulations have often been accused of pursuing this policy as a way of increasing their own institutional power and expanding their operations. Although there is some indication that drug enforcement authorities may have benefitted in these ways in later periods, there is little evidence that this was happening in the years 1915-1921—the period in which the United States rapidly moved toward a policy of criminalizing its addicted citizens.

Key leaders in the Department of Treasury policy makers shifted the intent of the Harrison Act from one of control to one of criminalization based on two errors: 1) a misreading of American public sentiments about psychoactive drugs, and 2) a fundamental misunderstanding of the nature of addiction. Administrative interpretations of the Harrison Act were based on the following assumptions:

1. The wave of early 20th-century anti-alcohol, anti-tobacco, and other anti-drug

movements is a clear expression of the American desire to rid the country of psychoactive drug use. This assumption was simply wrong. Federal officials mistook America's concern about drug-related problems (e.g., the saloon or the opium den) for a desire to banish alcohol, tobacco, and other drug use. This assumption failed to foresee the collapse of the turn-of-the-century anti-tobacco movement, the reversal of support for alcohol prohibition, the subsequent "celebration" of alcohol and tobacco (its central role in the country's domestic and economic life), and the lasting attraction of many Americans to other drugs. The Treasury Department saw widespread psychoactive drug use as a passing fad that could be taken care of by administrative resolution instead of what it has proved to be: a difficult and deeply rooted problem that rises and falls in intensity but—above all—continues to exist.

2. Narcotic use is a voluntary vice sustained by weakness of personal character and high drug availability. Later history reveals that, for a large number of Americans, narcotic use was not a voluntary act that could be eliminated easily through social disapproval. Instead, it was something that became almost a biological necessity. This belated popular discovery of what it means (biologically and psychologically) to be addicted to narcotics is one that still competes with the centuries-old belief that addiction is a problem of lack of character and moral fiber.
3. It will be possible to suppress drug supply by controlling the importation of narcotics and monitoring their distribution by physicians and druggists. The belief that—in a free and capitalist society—drug suppression would not give birth to an illegal drug distribution system proved to be a grave error. This error took the management of drug addicts in America out of the hands of medical and public health authorities and turned it over to emerging multi-billion-dollar criminal empires that sought to expand its markets.
4. As the supply of drugs dries up, users will shed their habit voluntarily or respond to social pressure to "take the cure." Being cured is only a question of withdrawing from the drug and restoring one's physical and moral strength. In an era in which addiction treatment programs boasted 95% cure rates—and in which there was little formal understanding of the phenomenon of narcotic relapse—people opposed drug maintenance strategies based on the simplistic notion that sufficient pressure could force addicts into a permanent abstinence. If anything can be learned from the years that followed drug criminalization, it is that narcotic detoxification does not constitute a cure.
5. Physicians who prescribe more than a few grains of narcotics, or prescribe narcotics on a continuing basis, are scavengers who cater to the depraved appetites of addicts for purposes of financial profit. Between 1918 and 1938, this assumption led to criminal charges against some 20,000 doctors, most of whom were merely doing what they had been trained to do—relieve the suffering of their patients (Willaims, 1938, p. xix). This assumption placed a moral and criminal value on the dosage a physician wrote on a prescription pad. It completely disregarded the phenomenon of tissue tolerance. Patients with extreme, stubborn pain needed exceptionally high dosages of narcotics. Not only did these dosages fail to produce pleasure, but they barely contained the physical agony and despair produced by the patients' medical conditions. The suggestion that doctors are morally bound to treat patients with extreme acute or chronic pain with the same brief, low doses that would work well in those whose pain is brief and responsive stands as one of the most destructive and inexcusable government invasions ever made into the practice of medicine. Administrative interpretations of the Harrison Act

removed the judgment of “good-faith medical practice” from the medical community, turning the evaluation of medical practices over to an adversarial legal system and a jury of citizens who knew little about medicine and even less about addiction.

6. By stigmatizing drug use, drying up drug supplies, and forcing users to shed their habit, we can virtually eliminate the narcotic drug problem in the United States. Once committed to this grandiose proposition, government officials have continued for nearly a century to suggest that the problem of narcotic addiction would be eliminated if only they could be given enough financial and legal resources. At no time has anyone operating on this assumption admitted that this goal is an impossible one—or that the human rights violations that would be necessary even to come close to this goal would fundamentally alter the character of American society.

The assumptions examined above led to continued federal involvement in the problem of drug use. In 1922, Congress passed legislation that tightened controls on narcotic imports and exports and increased the maximum penalty for violation of the Harrison Act from five years to ten years in prison. This began a cycle of ever-intensifying criminalization of addiction, a cycle that later led to 20-to 40-year sentences, then to 99-year sentences, and eventually to life imprisonment and the death penalty. Actions based on these assumptions continued in the decades following the 1920s, and continue today in new forms.

The interpretation and implementation of the Harrison Act did have its early critics. In their classic 1928 work, The Opium Problem, Dr. Charles Terry and Mildred Pellens pushed for a more medical approach to narcotic addiction. Dr. Henry Smith William’s 1938 book, Drug Addicts Are Human Beings, provided a blistering account of the ways in which federal policies had turned patients and their doctors into criminals and spawned illicit drug markets across the country. These early criticisms were followed by Dr. Alfred Lindesmith, who emerged as the most vocal mid-twentieth century critic of American Narcotic Control policies.

Between 1909 and 1924, while federal action sought to control problems related to opiates, cocaine, and chloral hydrate, efforts were also underway that thrust America into one of the most fascinating decades of American history. As the effects of the Harrison Tax Act unfolded, America also entered the “Noble Experiment” of alcohol prohibition.

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