

# The Drug Hang Up, America's Fifty-Year Folly

by Rufus King

## Chapter 17

### Follow-the-Leader in State Capitols

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BEFORE THE TURN of the century there was little public concern with drug abuse at any level of government, although an occasional warning was heard about possible dangers. Beginning with a San Francisco ordinance in 1875, a few local communities where opium smoking threatened to become widespread had enacted measures aimed narrowly at the nuisance of opium "dens," and in some jurisdictions the unregulated sale of opium and cocaine was also prohibited. Kansas and Tennessee passed the first prescription laws, in 1902, and a handful of other states followed. The American Pharmaceutical Association had taken note of the problem obliquely in relation to proprietary remedies as early as the 1870's, and began promoting uniform state legislation on patented nostrums in 1902. But for the most part these early provisions amounted merely to requiring pharmacists to keep some kind of register of drugs dispensed, as in the case of poisons.

It was the patented drug preparations that first stirred public and official interest. In 1904 a series of scandals was touched off by revelations about adulterated food and secret ingredients in drug preparations. Despite one of the most powerful propaganda agencies of its day, the Proprietary Association of America, which purportedly represented a \$75-million-per-year industry, the nostrum promoters were battered by publicity about the true alcohol and opium content of some of their most popular household remedies (Kaufman's Sulphur Bitters-40 proof; Kopp's Baby Friend-morphine; Ayer's Cherry Pectoral--heroin), -and particularly by a disclosure that when some of these same proprietary items were exported to England they were required to carry across their labels a conspicuous black legend, "POISON."

The American Medical Association soon became committed to this fight, demonstrating how much power it could muster on occasion, organizing flying squads of physicians to stir up community leaders and press for federal legislation and at the same time trying to combat local abuses through its own membership and such related groups as it could influence.

In 1905 President Theodore Roosevelt added his support, and with a final push from Upton Sinclair's great *Jungle*, which shocked the nation with its portrayal of conditions in the Chicago stockyards, Congress was induced to pass the first federal Food and Drug

Law. Under its provisions, purveyors of drug compounds were merely enjoined to indicate the contents of their preparations on their labels if they shipped in interstate commerce, but passage of the federal Act awakened new interest in the subject and stimulated parallel action among the states.

By 1912 every state but one (Delaware) had enacted some controls on prescribing or selling opiates and cocaine, although the provisions were usually hortatory, either without sanctions or backed only by nominal misdemeanor penalties. The most effective control of prescription practices remained the possibility of censure, or even license revocation, through self-policing bodies within the medical community.

However, the situation changed abruptly after passage of the Harrison Act and the emergence of the Treasury Department as a federal enforcement agency. Medical doctors were soon put on the defensive even in the legitimate use of controlled drugs. Not only would the T-men tolerate no ministrations to addicts with respect to their addiction, but even in cases where analgesics were medically indicated, such as painful terminal illnesses, the agents showed little deference toward medical prerogatives. As Commissioner Anslinger once told an investigating committee:

There is complete cooperation and a feeling of confidence between the enforcement officer—he does not act like a policeman, in other words. He is more in the nature of a fatherly advisor. And one thing about these professions: they lean on the enforcement officer a great deal for advice. . . .

Now and then you will find there is a weak link probably in a state. . . . We always catch up with him very quickly, and certainly he is brought to heel very quickly.

In the savage twenties, accordingly, little was done about controlling drug abuse at the state level; enforcement was so dominated by the federal men, and doctors and pharmacists handling drugs in legitimate channels were so intimidated, that there were virtually no borderline regulatory problems to be disposed of. A few states followed New York's Town-Boylan Act—Massachusetts, Rhode Island, and Pennsylvania had similar control laws by 1921—but the burden of enforcement was left to the national authorities.

However, shortly after the new Narcotics Bureau was established in 1930, the federal agency itself began to push for supplementing state laws. The Harrison Act grounded only on the federal tax power, so there was no question of preemption, and a wide range of overlapping state-law offenses could be created without raising problems of double jeopardy. In 1932 the National Conference of Commissioners on Uniform State Laws, the quasi-official body which prepares model legislation in areas where all the states have similar interests, promulgated a Uniform Narcotic Drug Act, patterned after the Harrison Act, which set up a strict system of licensing and controls tied directly to the federal procedures, and brought into play a full range of separate state criminal penalties.

The all-important exemption for medical prescribing was written into the state act in the federal language: "in good faith and in the course of his professional practice only."

Restricted drugs could be possessed lawfully by an unregistered person only if they had been obtained by a valid prescription, and then only if they were still in the container in which they had been lawfully delivered. One innovation in the Uniform Act was aimed specifically at physicians, pharmacists, and other professional persons: upon conviction of a narcotic offense, the state judgment and sentence had to be filed with any professional licensing board or registry by whom the convicted defendant had been licensed or registered, and the court might, in its discretion, summarily suspend or revoke any such license or registration.

Evidence of the ubiquitous influence of the Narcotics Bureau appeared in another unusual provision, which made it the express duty of all state and local enforcement authorities "to cooperate with all agencies charged with the enforcement of the laws of the United States . . . relating to narcotic drugs."

As originally drafted, the Uniform Act contained optional language for bringing cannabis under state controls. But in 1942 amendments were promulgated by the commissioners to parallel the 1937 federal Marijuana Tax Act and bring the latter drug arbitrarily into the full pattern.

The Uniform Act was endorsed by the American Bar Association and other groups, and was quickly passed by a majority of the states. Even legislators in places where there was virtually no drug problem responded to the lure of a popular cause which had no articulate opposition and which affected no one who could hit back. By the end of the 1940's every state except Kansas, Massachusetts, New Hampshire, and Washington had adopted the Uniform Act, and these four had comparably repressive statutes of their own. Uniform acts are traditionally promulgated without recommendations as to penalties, and in the early days most state sanctions tended to be lighter than the federal, maximum terms of imprisonment running not infrequently to no more than six months or a year, and maximum fines from \$500 to \$1,000 (the usual top range for misdemeanor categories).

In 1937, in connection with the marijuana hullabaloo, Congress introduced increased penalties for second and subsequent drug offenses against federal laws, and these recidivist sanctions thereupon made their appearance in some of the state codes. But it was only after Congressman Boggs pushed through his extreme minimums and exaggerated punishments in 1951 that state lawmakers-again with vigorous pressure from the Narcotics Bureau -started to respond with enactment of what came to be known as "little Boggs acts." Ohio led off, with penalties for possession of from two to fifteen years for a first offense, five to twenty for a second, and ten to thirty for any subsequent conviction, with harsher mandatory punishments for sales, commencing at ten to twenty and jumping to thirty to life. New Jersey followed, with graduated general penalties of two to fifteen years, five to twenty five, and ten to life, coupled with ingenious embroidery such as punishing any physician who learned of a case of addiction and failed to report it promptly to the authorities, anyone who induced any unlawful use of a drug, and anyone who merely was a drug addict (treated as a vagrant, \$1,000 fine or one year or both). Nearly a dozen states followed the New Jersey line in one way or another,

making the mere status of being a drug addict a separate offense, until the Supreme Court at last held all such provisions unconstitutional, in *Robinson v. California* (1963).

New Jersey also drew resounding praise from the Narcotics Bureau for pioneering a statute which required, on pain of misdemeanor sanctions, any person who had ever been convicted of any crime involving narcotics and who planned to remain in the state of New Jersey longer than twenty-four hours to complete a long registration form with his name, aliases, arrest record, and prior places of residence-which, with a photograph and fingerprints, was then circulated to all state and local police agencies. (The moving force behind these Bureau-blessed innovations in the Garden State was William F. Tompkins, then U.S. Attorney for New Jersey, who subsequently turned up as Anslinger's coauthor on *The Traffic in Narcotics*, and then appeared in Washington as President Eisenhower's appointee to head the McCarthy-spawned Internal Security Division in the Department of justice. )

State after state jumped into the ten-twenty-fourty-year category, with severe mandatory minimums, and not a few added maximums of life imprisonment or even death for flagrant transgressions. The federal pattern was also frequently followed in wiping out eligibility for probation and parole among convicted drug offenders.

But since most states had neither the funds nor the personnel to enforce these laws vigorously, what often happened was that Treasury agents could decide, after they had made each case, whether it would be more hurtful to the defendant to prosecute him in a federal court under the federal law, or to turn him over to the state for prosecution (while often retaining actual control) under some suitably harsh state statute. The option was particularly useful to the T-men where safeguards as to confessions, entrapment, search and seizure, and the right to counsel were weaker in state criminal practice than under the federal Constitution as applied in federal courts. (It was in ending such disparities, by expanding federal standards to cover state practices, that the Warren Court stirred anguished protests from the law enforcement community. A disproportionate number of the worst constitutional abuses have always arisen in narcotics cases, and the Anslinger forces were always prominent among the protesters.)

A few states have long included drug addicts in civil commitment procedures allowing the incarceration of inebriates and insane persons, and in the 1950's, besides the new measures making addiction per se an offense punishable by imprisonment, much attention was given to methods by which the addict might be removed from society involuntarily through such civil procedures. Nearly a score of state legislatures passed laws under which persons found to be addicts might be turned over to probation officers or public-health authorities for "treatment," either for a maximum term or for an indefinite period until they were "cured." The difficulty was that with the exception of three jurisdictions-California, New York, and, for a while, Illinois the legislators contented themselves with passing tough-sounding new measures and exchanging accolades with one another without making any corresponding appropriations or provisions for suitable treatment facilities.

The net effect was that these civil-commitment laws often gave local prosecutors a second line of attack: if they could not convict an addict for such criminal offenses as possessing either drugs or paraphernalia (a number of states had made unauthorized possession of hypodermic needles unlawful), they could institute proceedings for involuntary commitment on a noncriminal basis. And the addict would wind up imprisoned just the same, often in the same Penal institution. Some of the least-affected jurisdictions blossomed forth with most elaborate civil statutes; Colorado, Florida, Iowa, and Mississippi, for example, all have statutory machinery for committing and confining addicts until cured, and then following them indefinitely with probation supervision.

Apart from these inadequate and misdirected commitment laws, and the three states mentioned above, no programs of significance were developed in any local quarter to provide care for addicts. The Bureau forbade any facility that might remotely suggest revival of the so-called clinics. And although they gave lip-service to the distinction between mere users and peddlers, Anslinger's men consistently waged their enforcement war indiscriminately against both, so that an overwhelming majority of persons convicted for drug offenses continued to be addicted victims of the traffic.

In responding to the problems this caused in administering the federal prison system, Congress had been induced in 1929 (over the bitter opposition of the then Surgeon General) to authorize the establishment of two special facilities, first called "narcotic farms" and later renamed "hospitals," to be administered by the Public Health Service. The first of these opened in 1935 at Lexington, Kentucky (headed by Dr. Kolb, as we have noted), although a limited drug-research program had been initiated several years before in clinical facilities at Leavenworth Penitentiary. The second, at Ft. Worth, Texas, was opened in 1938.

Under the 1929 federal law, addicted persons convicted of crimes in a federal court could be sent to the Public Health Service hospitals by the sentencing judge in lieu of being committed to ordinary imprisonment, and this became the principal function of the hospitals, which were, in fact, run like mediumsecurity penal institutions. But the law also permitted the hospitals to accept voluntary addict-patients who applied for admission. It soon became apparent that most of these voluntary applicants, who were under no compulsion to stay for any fixed period, would leave as soon as physical withdrawal had been accomplished and they began to feel the first symptoms of genuine relief. It even appeared, sometimes, that the addict's primary purpose in committing himself was to reduce his tolerance to a manageable level so that he could resume drug dependence with a smaller daily intake.

The hospital authorities had determined that the minimum therapy regime which gave any promise of success was about six months, so a makeshift arrangement was worked out with local courts in Lexington. Under a Kentucky statute making drug addiction a one-year misdemeanor, voluntary applicants were processed by what came to be known as "blue-grassing"-being required to plead guilty to addiction before a Lexington judge and to accept a previously agreed upon one-year sentence, which the judge would then suspend on condition that the addict submit himself to hospitalization. This system,

raising grave constitutional questions, was only partially successful, however, and was eventually abandoned (and simultaneously held to be invalid by a federal court anyway). Thereafter the hospitals screened their voluntary applicants severely and cut back on the number of noncommitted admissions they would take.

Even though the Daniel Subcommittee had called for permanent "quarantine" of addicts and a bill to permit federal hospitals to accept patients referred by the states had been introduced in 1956, nothing was done along this line, as Congress saw fit only to toughen the criminal sanctions. But these federal recommendations gave new impetus to programs in California and New York, where the addict population had begun to concentrate after World War H. In California, an elaborate measure specified that no physician could treat narcotic addiction by administering drugs even in reduced amounts except when the patient was in confinement in an approved private institution or a jail or public hospital, and that each such treatment had to be reported to the authorities by the physician; the law even prescribed limits on permissible dosages. Persons addicted to narcotic drugs-or to any other habit-forming substance "so far . . . as to have lost the power of self-control"-could be committed for a period of up to two years to the California Department of Mental Hygiene. The Department soon developed extensive treatment facilities, also working out a genuine follow-up system for keeping track of addicts when they returned to the community.

New York, which has long spent more on the Rehabilitation of addicts than the entire federal budget for the same purpose, also initiated a hospital-commitment program at this time, making use of the state's general mental-health facilities. Simultaneously the state, with New York City, opened the Riverside Hospital project, where addicted persons under twenty-one years of age could be treated and then carried on an outpatient basis for a maximum of up to three years.

Each time a new problem is faced in the District of Columbia, it is asserted with boring monotony that since the District is a federal jurisdiction it should become a trail-blazing model and set standards to inspire all the states. That was the cry in 1953 when Congress, in a flurry of ringing pronouncements about how Washington's drug problems were going to be solved once and for all, passed an act setting up involuntary civil commitment for District addicts so that they could be sent to the Public Health Service Hospital at Lexington. However, no one in the entire enacting process bothered to note that there was nothing in the U.S. Code which could be stretched to authorize Lexington to accept patients so committed, and the D.C. statute commenced as a dead letter. By the time the Lexington authority was properly adjusted two years later, Washington's program had lost momentum and never amounted to anything more than a token facility loosely combined with the inadequate bedspace provided for the treatment of alcoholics.

In wartime research during the 1940's a new series of alkaloids was discovered to have acute antagonizing effects on the symptoms of morphine poisoning. These substances, the best-known of which is N-allynormorphine, manufactured under the trade name Nalline, precipitate the withdrawal syndrome when administered to an addict who is on an opiate. California authorities, followed by probation officials in a few other

jurisdictions, seized upon this drug as a way to keep track of purportedly cured addicts when they returned to society. As a condition of release from prison or civil commitment, the addict was required to present himself periodically for injections of Nalline, which generally produced no effects unless he had resumed the use of a narcotic.

In some quarters there was always strenuous opposition to the use of this Control, at least on a compulsory basis, not only because Nalline, if inexpertly administered, is dangerous and capable of producing side effects, including death, but because of the inherent repulsiveness of coercing people with drugs, and especially of compelling abstinent addicts to submit to a procedure involving injections. As Dr. Kenneth Chapman has stated:

Nalline has certain possibilities to be used as what we would call-and I use a psychiatric term here-a chemical super ego. I am personally and unequivocally against using any drug to coerce anybody to do anything, any time, anywhere. This is one of my personal, moral and ethical convictions. . . .

I think there is a great danger, in addition, that this will become a short circuit, a substitute for community rehabilitation. This is what we have seen all along in the whole field of treatment of narcotic addiction. We build big hospitals, more institutions, a lot more people keep talking about length of time intramurally, but we don't do one thing about treating the persons in the community except to try to set up some quick, short circuit substitute for keeping him off drugs.

The California authorities subsequently found that small dosages of Nalline usually produced characteristic pupillary reactions in drug-intoxicated addicts, without the more violent symptoms and high risk of adverse side effects. But this procedure was not very accurate, giving false negatives and positives in possibly 15 per cent of the subjects tested.

The latest "chemical super ego" is urine testing by thin-layer chromatography and gas chromatography, which can be performed on very small samples, is more accurate than Nalline, and is free of danger. Although these tests require some expertise and laboratory equipment, they have dropped steadily in cost from \$20 to \$30 to less than \$3 per test. New York, California, and the District of Columbia now make extensive use of the thin-layer procedure to supervise released addicts and parolees. New York Illinois, Maryland, California, and a few other states are also experimenting with more or less voluntary testing of some school groups in high-addiction areas.

In 1970 local District of Columbia courts handling run-of-the-mill criminal offenders began requiring anyone charged with a drug offense, who had a record of addiction, or who looked like an addict, to have a urine test at the time of his arrest (with the implied threat of denial of bail for those who refused), and ordered urine-test supervision for halfway house inmates and probationers and parolees as a condition of release in these categories. It was soon found that elaborate precautions were necessary to prevent skullduggery with samples; each donor was color-photographed for identification and

observed in each offertorial act; and still the processing of hundreds of tests daily remains somewhat hit or miss.

The District of Columbia court program provided specifically that no test results could under any circumstances be used as evidence or to incriminate the subject in any other way. But notwithstanding this concession (probably required by the Constitution anyway), the program has been frankly aimed at coercing abstinence. The same testing procedures can be effective, if elaborated, in disclosing the presence of nonaddicting drugs like amphetamines and even cannabis. They will not differentiate heroin from morphine, however, since the former, despite all the claims as to its danger, metabolizes exactly like the latter, and the procedures are so sensitive to nicotine and alcohol that great care must be taken to avoid false positives from boozers and chain-smokers.

Urine testing will certainly play a useful role as an adjunct of genuine therapy, and is already being used with good effect in some of the methadone programs, as we shall see. But it is also, alas, stirring the interest of many enforcement-minded lawmakers. Compulsory test measures to be administered by police authorities have already been introduced in a number of state legislative sessions. So it is likely-indeed certain-that our drug cops are soon going to be set prowling among us with sample bottles, and that to-the full extent allowed by the courts at least some jurisdictions will try coupling mass testing with civil commitment and conditional release. Messrs. Anslinger, Daniel, and Boggs could scarcely have foreseen anything more to their liking.