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SUBSTANCE ABUSE AND AMERICA: HISTORICAL PERSPECTIVE ON THE FEDERAL RESPONSE TO A SOCIAL PHENOMENON

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Much more often than is commonly given credit, factors other than a substance's therapeutic efficacy contribute to its affect on the individual experience, its own proliferation, and society's response. To explore these dynamics, American history is examined from the perspective of analyzing the development of substance abuse. Of the conclusions borne out by this historical perspective, foremost was that psychoactive substance use has been an element in the American social ecology from its earliest beginnings.

The health professions have not always exhibited behavior in the interest of public health, and, most importantly, the federal response has often been plagued with outcomes that have been less desirable than many of the problems.

This historical review supports the thesis that drug-seeking behavior and the response it elicits are in a constant state of flux and cannot be adequately appreciated in isolation from the sociocultural and historical contexts in which they occur.

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Although history has intrinsic interest, its many implications prove to be more valuable as a background for considering the extent and meaning of psychoactive substance use today. Because fact is not easily separated from fiction concerning the use and properties of many substances, a historical review also helps to appreciate the differences between proven pharmacological actions of a

given substance and the contributions from those other forces, be they social, economic or political, which influence the individual's experience with a drug, the substance's proliferation, and the societal response.

One issue, which to some may seem quite obvious, must be underscored: American federal drug policy is not necessarily synonymous with American public policy in drug use. It is true that government must respond sufficiently and in a timely manner to urgent needs, irrespective of the immensity of the problem; however, the role of regulatory legislation in drug use, misuse, or abuse is fairly limited. However, changes in national or local drug policies cannot, of course, significantly precede the evolution of public opinion. It is not easy to determine to what extent patterns of drug abuse are due to legal pressures and to what extent these patterns are due to or cause pressures of religious attitudes, cultural differences, and socioeconomic stresses. Finally, the compatibility of the political process with an appropriate level of commitment on the part of the government has been the subject of much discourse.

Nonetheless, history can aid in the identification of which changes in society effect changes in drug use, which segments of the population are most susceptible to the attraction of certain substances and under what conditions, which factors determine the geographical distribution of substance use, and which characteristics of society have moderated or aggravated the deleterious potential of psychoactive substance use.

BEFORE 1840

Alcohol and tobacco use are well documented in colonial American history[1,2]; however, the earliest mention in the literature concerning abuse of a substance is in reference to alcohol.[1] The 17th century marked the first local legislation governing alcohol consumption by licensing and taxing the sale of alcoholic beverages.[3] Probably the most persuasive evidences of early American concern were the recommendation by the First Continental Congress that the "pernicious practice" of distilling grain be curbed,[4] and the Whiskey Rebellion (1794) from which the newly formed federal government received its first test of authority from Pennsylvania farmers protesting a federally imposed liquor excise tax.[5] These early laws were not so much a reflection of governmental concern as attempts to use the increasing popularity of alcohol as a source of considerable revenue, setting a precedent that would be repeated often in the future.

Noteworthy for the beginning of the temperance movement and the first institutions specializing in problems with drinking,[6] the era was further characterized by the many ways alcohol or tobacco were used. Although neither alcohol nor tobacco were considered respectable, alcohol's association with drunkenness led to what Gusfield described as "assimilative reform."[7] Contrary to "coercive reform" or legislative compulsion, "assimilative reform" was a policy favoring the encouragement of limited consumption through reasoning, moral persuasion, and exhortation. Finally, alcohol represented the first substance in American history which was used in the oppression of an ethnic group, the American Indians. The myth of Indians being more prone to drunkenness resulted in social condemnation, laws totally prohibiting Indian consumption of alcohol, and more fuel for the temperance movement.

1840-1890

During the pre-Civil War period, per capita consumption of opiates, mostly imported, skyrocketed. Tobacco smoking, mostly in terms of cigars at this point, grew to 26 per capita,[8] while, simultaneously, drinking increased as beer consumption alone reached 2.17 gallons per capita.[9]

The Civil War itself had differential effects on substances of abuse, serving as a catalyst to opium and tobacco use and having exactly the opposite effect on alcohol use. In the case of tobacco, cigarettes became an established military ration[10] and a highly significant source of revenue for the war effort with the enactment of the first federal excise tax on tobacco.[8] The medicinal use of opium as analgesia in the treatment of war casualties more than compensated for any decline attributable to

the blockade of southern states. Alcohol, on the other hand, fell into disrepute as the Civil War marked the high point in the first wave of state-legislated prohibition laws and a federally imposed tax on alcohol was less lucrative as a revenue source than originally anticipated.

The post-Civil War era was remarkable for the steady increase in the use of tobacco, alcoholic beverages (predominately beer), and opium, and the beginnings of concern with another substance—cocaine.

Following the repeal of the initial wave of state prohibition laws, all these substances were legal, but far from being considered either respectable or a threat to society. This probably partially explains the failure of the first prohibition amendment to the US Constitution.

On closer examination of this period a number of points should be stressed regarding the relationship between psychoactive substance use and the federal response. Rural and middle class America had become progressively discontent over their perceived loss of status during a period of increasing industrial expansion and immigration. This, together with the support of many churches and the strong efforts of temperance forces, formed the overwhelming majority of the prohibition political base. However, prior to the effective organization of these groups, the powerful tobacco and alcoholic beverage interests, the advertising blitz by the proponents of these substances in concert with the craze over patent medicines (containing varying amounts of opium, heroin, and cocaine), and the almost universal acceptance of these substances by physicians and pharmacists as cure-alls[11] led to an almost insatiable demand for psychoactive substance use.

As in earlier times, psychoactive substance use continued to serve as a mechanism to promulgate elaborate and massive social and legal restraints against two more repressed groups, the Chinese and the American blacks. As Musto[12] explains, the custom of opium smoking of the early Chinese immigrants was labeled as one of the subversive activities of the Chinese against American society. In regard to black people, the fear of cocaine was used as a political ploy in the South to rationalize lynchings, segregation, and other tactics to keep blacks in "their place." It is not surprising that the South and the West were strongholds for the prohibition efforts.

A final lesson spawned by this period of American history dealt with the complexity of the relationships between the patterns of abuse of different substances. Toward the end of the 1880s, a second wave of state alcohol prohibition laws swept this country with an appreciable decline in the consumption of alcohol, especially distilled liquors. It has been said that the increases noted in the use of opiates, tobacco, and cocaine were partly due to this latest effort on the part of proponents of prohibition. Whether this was true or not, the phenomenon of decreased consumption of one psychoactive substance occurring just prior to or concurrently with an increased consumption of another substance was to be continuously repeated.

1890-1914

While the United States was undergoing its second wave of state alcohol prohibition laws, many states also enacted laws regulating opium and cocaine. In spite of these state and federal laws regulating opium importation and taxing tobacco sales, use patterns were such that the consumption of tobacco, opiates, and cocaine had increased. Moreover, the proliferation of adulterated substances due to the ever increasing importation of foods, drugs, and other substances were of great concern to many. Consequently, Congress enacted the Food and Drug Act of 1890[13] which prohibited "the importation of adulterated or unwholesome food, drugs, or liquor," particularly those containing opiates or cocaine. Following enactment of this legislation, use of opium- and coca-containing products declined for a short time.

The early 20th century provided further indications of concern with psychoactive substance use. State regulation of cocaine, tobacco, and alcohol (the third wave) was the rule rather than the exception. Texas became the first state to outlaw marijuana use. Local laws were in response to increasing cigarette (attributable, in part, to a new milder cigarette and technological improvements in manufacturing),[14] cocaine, and opiate consumption (especially in "dry" states).

There was also activity on the professional front. The psychoactive effects of these sub-

stances were well discussed in medical circles. The American Medical Association established a Council on Pharmacy and Chemistry to research drug abuse. Pharmacists, although also concerned with the supply of these substances, were more interested in limiting the dispensing of these substances only to their profession.

The motivation behind the local legislation and involvement of the medical profession and trade interests stemmed from what historians have called "progressivism." This concept described a belief, commonly articulated by the politically influential, to use government intervention to affect the habits of large populations by well-written legislation and appropriate enforcement. No level of government was immune to these organized political efforts. In addition to these forces, the temperance movement and public health campaigns (which, in the case of nicotine consumption, did more to increase cigarette smoking than to decrease it) were obtaining greater support. Unfortunately, many of the local and state responses to these influences continued to be racially motivated, with the Mexican-Americans becoming the most recent addition to the oppressed minorities as a result of Texas antimarijuana laws.

With this backdrop, the federal response is particularly interesting. The unending lobbying of the medical profession and the pharmacists was probably the most influential force behind the enactment of the Pure Food and Drug Act of 1906.[15] Administered by the Bureau of Chemistry of the Department of Agriculture, this law required the labeling of over-the-counter drugs that contained any amounts of cocaine, opiates, cannabis, or chloral hydrate. It also "prevented the manufacture, sale, or transportation of adulterated, misbranded, poisonous or deleterious foods, drugs, medicines, or liquors." In retrospect, this law, at least for a short time, actually served to safeguard users and the drug dependent. In addition, following passage of this legislation, sales of proprietary medicines containing psychoactive substances temporarily declined. The eventual increase in the consumption prompted a reevaluation by federal authorities.

As a consequence of the increasing domestic concerns with opium consumption patterns, the State Department's interest in ameliorating the tension between the United States and China, and President Roosevelt's desire to use international meetings as a forum to promote the United States into the ranks of the foremost powers, Congress enacted a 1909 amendment[16] to the 1906 Act. Publicized as a token of American concern about the international narcotics traffic and enacted following the US participation in the first international meeting, the Shanghai Opium Commission, this law prohibited the importation of smoking opium and established a prohibitive tax on domestically produced smoking opium. Moreover, importation and use of opium was limited to medicinal purposes.

In the case of the federal response to the use of other psychoactive substances, two actions are noteworthy. In response to the increasing unconscionable advertising of the pharmaceutical industry and the lobbying of the medical profession, the federal government reacted with a 1912 amendment[17] of the 1906 Act, prohibiting false statements of curative or therapeutic efforts on drug labels. Additionally, the passage of the Webb-Kenyon Act (1913),[18] making it illegal to ship liquor to states where its sale is prohibited, and the removal of whiskey and brandy from the standard list of drugs on the *US Pharmacopeia* reflected the growing number of dry states.

The climax of federal involvement during the era of progressive reform was the Harrison Act (1914).[19] In the background of well publicized associations between tobacco and alcohol, between alcohol and opium, and between opium and crime, the attitudes of pre-World War I America culminated in regulatory laws directed at foreigners and ethnic minorities. Although the foregoing was important, the federal response was motivated more as an attempt to fulfill the US obligations in international agreements. Resulting from the 1911 and 1912 Hague Conventions, these agreements consisted of promises by member countries to restrict opium production to medical and scientific research, to enact laws prohibiting opium use, and to control the manufacture, sale, and use of morphine and codeine.

Although the Harrison Act was ostensibly a tax measure designed to regulate the distribution of opium, cocaine, and their derivatives (except decocainized coca), its administration went far beyond what was originally anticipated. The Act required "all persons who imported, manufactured, distributed, or handled the regulated substances to register and pay an occupation tax." However,

the Act, on its surface, did not purport to interfere with the practice of medicine by the inclusion of a clause allowing use by "a physician, dentist or veterinary surgeon registered under this Act in the course of his professional practice only." However, the interpretation of this very same clause by the Bureau of Internal Revenue, the administrative agency of the Treasury Department, in effect turned this into a prohibition law. The Bureau determined that opiate dependence was not a disease and that dispensing or prescribing opiates to dependent persons was not "in the course of his professional practice" or "for legitimate medical purposes."

1914-1933

Interestingly enough, the Harrison Act came in the aftermath of consultations with professional and trade groups, due to American international obligations and with the support of many reform interests, but was not an issue of primary national interest. Similarly, the question of controlling nicotine, cocaine, and marijuana had none of the controversy associated with alcohol prohibition. Tobacco, itself, had become an invaluable aspect of the US economy. Indeed, in spite of the fact that many states had prohibited the nonmedical use of marijuana, cocaine, and opiate products, most Americans only used the term temperance in regard to alcohol consumption and not opiate or cocaine use. In fact, as time went on, maintenance therapy became a well accepted concept. On the other hand, alcohol prohibition became a highly inflammatory issue. Nonetheless, the first attempt at passage of a prohibition amendment met with failure.

However, upon entrance of the United States into World War I, prohibitionists took advantage of the war effort to increase their public support. Shrewd anti-narcotic proponents rode the crest of the increasing popularity of alcohol prohibition. Together, these forces played important roles in the Red Scare (1919-1920). During this era, beer was associated with the Germans and together with narcotic use was considered a threat to the national war effort. More importantly, concern over these issues mounted as nationalism and an enormous fear of Bolsheviks swept the country.

As a result of the foregoing, what had been considered a reasonable viewpoint in earlier years—the value of maintenance therapy by the medical profession and others—had become akin to the dreaded socialism. Consequently, the few maintenance clinics in existence received diminishing support and drug dependence was viewed as a police problem.

The federal response was extremely rapid and unwavering. In regard to alcohol, the 18th Amendment and Volstead Act (1920)[20] prohibited alcohol consumption. While providing detailed legislation under which the 18th Amendment could be enforced, the Volstead Act also established the Narcotics Division of the Prohibition Unit of the Treasury. As the country's first narcotic law enforcement unit, this agency launched a successful campaign to close narcotic-dispensing clinics without adequately evaluating the extent to which alleged abuses were prevalent nationwide and the impact these abuses had on illicit supply.

Curiously, this agency, by publicizing marijuana as the worst evil of all psychoactive substances, did more to popularize cannabis use than to discourage its use. In addition, the role of the Supreme Court in shaping the federal response is evidenced by a number of its rulings[21-23] being in part responsible for the 1922[24] and 1924[25] amendments to the Harrison Act. These amendments provided sterner maximum federal penalties, extended the prohibition provisions to cover coca leaves, cocaine, and opium derivatives, and prohibited heroin importation entirely.

The next significant piece of legislation was the Porter Narcotic Farm Bill (1929).[26] Following further legislative restrictions based on the Harrison Act, the drug dependent population of federal prisons grew considerably. In an attempt to remedy this situation and over the protests of the Public Health Service, this law authorized the establishment of two narcotic treatment centers for convicted drug dependents to be supervised by the Public Health Service. Besides marking the beginning of the federal role in addiction treatment, this law provided the training ground of the future leaders of agencies which were to eventually have a large part in federal treatment, rehabilitation, and research efforts. Unfortunately, these narcotic farms, one in Lexington, Kentucky, and another in Fort Worth, Texas, did not open until many years later.

By 1930, prohibition was separated from nar-

cotic control as the Federal Bureau of Narcotics succeeded the Narcotics Division of the Prohibition Unit. Prohibition, itself, was transferred to the Justice Department. Finally, as this era closed, the first amphetamine was marketed and the Prohibition Amendment was repealed with the passage of the 21st Amendment in 1933.

1933-1960

On closer inspection, the last years of the Prohibition era were particularly interesting. In the background of increasing convictions for liquor offenses, nicotine and marijuana consumption skyrocketed, due to the laxity of enforcement of marijuana laws with federal agents concentrating on alcohol prohibition affairs and the mass production and marketing of cigarettes. The failure of Prohibition could be traced to two critical points. One, most Americans were not against moderate alcohol consumption, but rather excessive drinking. Consequently, illicit use continued to rise in spite of ever increasing enforcement efforts and sterner penalties. Secondly, the Great Depression was used as evidence by anti-prohibitionists that Prohibition was hurting the economy by increasing unemployment and depriving the government of tax revenue.

Prohibition, while in effect and immediately following its repeal, had serious consequences for movements against other substances. The decline into defeat of the antitobacco crusades exemplifies one of the consequences. In addition, the experience with Prohibition solidified the concerns of many federal authorities that control of psychoactive substance use should remain a state matter, especially when use was confined to distinct regions of the country.

Evidence for this includes the following: (1) the pressure put on the National Conference of Commissioners on Uniform Drug Laws to develop a model law for states to enact came almost entirely from the Federal Bureau of Narcotics (FBN); and (2) the FBN's aggressive encouragement that each state adopt laws patterned after this model, called the Uniform State Narcotic Act, and its acceptance by many states typifies the predominant feeling that enforcement, in the main, should remain with the states.

Following the ever more vigorous protests of southwestern authorities, the federal government was pressured to depart from its stance and respond to the ever increasing concern about marijuana use in that region. Upon examining the motivation behind the pressure from the southwestern states, one finds that the marijuana issue was used to obtain stricter federal barriers to Mexican immigration so that these states might be able to rid themselves of an unwelcomed manpower surplus in regions devastated by unemployment. Nonetheless, the federal response was the Marijuana Tax Act (1937).[27]

By 1937, an overwhelming number of states had passed laws subjecting marijuana to the same rigorous penalties applicable to heroin and cocaine, one of the indications of how marijuana was commonly and erroneously categorized as a narcotic. Thus, many states looked to Washington for a federal extension of their state laws, but, to their chagrin, this was not entirely the federal response. Carefully written as a separate revenue act apart from the Harrison Act so as to discourage court challenges, this law requires that all manufacturers, importers, dealers, and practitioners who deal with marijuana register and pay a prohibitive tax.

To close out the third decade, two other occurrences are worth mentioning: the discovery of LSD and the passage of the 1938 Food, Drug, and Cosmetic Act.[28] This Act provided authority for comprehensively regulating the entry of new drugs into interstate commerce and stipulated a requirement of safety for approval of new drugs.

In the 1940s, psychoactive substance consumption patterns changed demonstrably. Although cigarette and marijuana use continued to rise sharply, amphetamine and LSD use were making only small gains in quite limited circles, while cocaine use declined. Federal involvement in this era included enactment of laws increasing cigarette taxes and banning the domestic cultivation of opium poppies nationally.[29] Furthermore, structural changes were made which were to play a significant role in future federal efforts. Renaming the Mental Hygiene Division the National Institute of Mental Health, consolidating all laws relating to the Public Health Service, and including synthetic drugs with "narcotic-like" qualities under the control of narcotic laws were among the most important changes.

Motivation for the above patterns of consump-

tion came from a number of areas. For one, as the United States entered World War II, enforcement and concern with marijuana waned and even the need for the 1937 Act was seriously questioned. Cigarette smoking became not only acceptable, but also socially desirable, with urban areas having heavier incidence rates. To combat soldier fatigue, the military substituted amphetamines for cocaine due to the longer duration of action and the oral mode of amphetamines. The role of the media started, aside from advertisement, to become prominent as it began a major campaign against nonmedical barbiturate use, popularizing what in reality had not been a real problem.

At mid-century, the American ecology continued to be plagued by many factors perpetuating psychoactive substance use. Publicity had proven to be more of an inducement to consumption than a mechanism to protect the public, particularly in reference to cigarette, barbiturate, and patented medicine use. Without a doubt, it served to lure people to barbiturate use[14] and provided the drug industry, through its many misleading advertisements, with windfall profits.[30] The first major warnings, issued jointly by the American Cancer Society, the National Cancer Institute, the American Heart Association, and the National Heart Institute, initially served to decrease cigarette smoking. However, because these warnings also resulted in a stronger reaction by the Tobacco Institute, a coalition of major cigarette manufacturers, cigarette consumption continued to skyrocket.[31]

Looking at the military and at the medical profession provides further reasons for the prevailing patterns of use, misuse, and abuse of these agents. The increase in amphetamine consumption and the concurrent decline in cocaine use was further induced by the fact that following the Korean War many of the returning veterans used amphetamines instead of cocaine in an intravenous combination with heroin because of their military experience with amphetamines and the high cost of illicit cocaine.[32] On the other hand, the impetus for LSD use came mainly from two civilian mechanisms. Members of the professions, particularly psychologists and psychiatrists, consumed LSD in social settings. Additionally, LSD consumption received a tremendous push as a result of having been used on volunteers in university and hospital experiments.

A full understanding of many of the actions taken by the Federal government during the 1950s would not be complete without mentioning what many consider a blemish on American history—McCarthyism. Fears of Communism, the Soviet Union, and China, similar to the earlier Red Scare, led to unwarranted levels of suspicion. As in the earlier period, narcotics, which then included cocaine and marijuana, were associated with subversive activities of alleged Communists or their alleged sympathizers. In this background, Congress passed laws imposing harsher penalties for narcotic convictions,[33] providing more control of narcotic drugs and marijuana[34] and providing for the deportation of an alien who, after having entered this country, is convicted of violating a narcotic law.[35]

The role of powerful interest groups should not be overlooked either, for in retrospect, they were influential in changing the federal response near the close of the fifth decade. Interestingly, the change in federal policies, although resulting from the efforts of these groups, was not welcomed by all.

As mentioned above, the drug industry was experiencing unprecedented prosperity. Having eliminated through industry pressure the American Medical Association's Seal of Approval program, which evaluated the efficacy of drugs entering the market, the drug companies continued to exploit loopholes in existing regulatory laws. Furthermore, it was widely held that the relationship between the industry and the Food and Drug Administration (FDA) was inappropriate at best. Ironically, these very same points brought Congressional attention, which eventually, spurred by the thalidomide tragedy, led to greater regulatory control.

One of the consequences of federal legislation was an interesting coalition between the American Bar Association (ABA) and the American Medical Association (AMA). Many in the legal community were of the opinion that much of the federal response was unjustly harsh and ineffective. Consequently, the ABA condemnation of the imposition of mandatory first offense sentences in narcotic convictions[36] was not surprising. At the same time, the liberal remnants from the early 20th century leadership of the AMA saw this as an opportunity to bring the medical profession behind a move to reevaluate the problem of psychoactive

substance use. In addition, physicians had become quite vexed with the Federal Bureau of Narcotics' (FBN) rigid enforcement of narcotic laws. Together, the ABA and the AMA issued a report[37] which criticized federal laws and law enforcers, called for new alternatives in dealing with drug dependency (without precluding narcotic dispensing clinics), and encouraged less harassment of physicians. Obviously, this report was not looked upon favorably by the FBN and, in fact, signaled a slip in the FBN position on narcotic matters.

Finally, one other interest group was increasing its influence. Many of the mental health personnel who held positions in the National Institute of Mental Health (NIMH), successor to the Mental Hygiene Division, had become disenchanted with FBN policies. These same persons who had worked on the "narcotic farms" were becoming increasingly convinced that drug dependence was a psychological or physical disease. As federal support of the NIMH increased, so too did acceptance of the latter view.

THE 1960s

In the entire history of American psychoactive substance use, this decade could be characterized as the most exciting (and yet quite frustrating). No branch of government was immune from involvement. In Congress, the major legislation included the requirement that health warnings appear on cigarette packages and, later, on all cigarette advertising.[33] After many years of debate, the Kefauver-Harris Amendments to the Food, Drug, and Cosmetic Act (1962)[38] provided that new drugs meet standards of effectiveness, in addition to meeting safety requirements. The Juvenile Delinquency and Youth Offenses Control Act of 1961 authorized the "prevention, diminution, and treatment of juvenile delinquency" including psychoactive substance use.[39] Grants were provided to states and communities for construction of mental health centers and narcotics "addiction" was included in definitions of mental illness.[40] Food and Drug laws were further amended to curb the black market in amphetamines, barbiturates, and other psychoactive drugs.[41] In 1966, Congress authorized support to cities to plan, develop, and implement programs to include drug treatment and rehabilitation services (revitalizing blighted areas),[42] as well as to include the civil commitment of "addicted" federal prisoners and "addicts" before trial and sentencing.[43] Treatment and rehabilitative services were further advanced for narcotics use,[44,45] as well as alcoholism in 1968.[46]

The role of the Supreme Court was not to be underestimated. As a direct consequence of *Robinson vs California*[47] and *Powell vs Texas*,[48] affirming the status of narcotics dependence and alcoholism as diseases, greater impetus was given to non-law enforcement alternatives to deal with the growing proliferation of psychoactive substance use.

An examination of a selected few agencies in the executive branch of government should provide an appreciation of the role of this arm of government. The impact of the Department of Treasury's Federal Bureau of Narcotics (FBN) has been mentioned earlier, but it was the Treasury's US Customs Service that played the crucial role in Operation Intercept, a dramatic, yet unsuccessful, effort of drug interdiction at the US-Mexican border in 1969. The Federal Bureau of Investigation's anti-glue sniffing campaign[49] and the combining of the FBN and the HEW Bureau of Drug Abuse Control to form the Bureau of Narcotics and Dangerous Drugs (BNDD) in the Department of Justice point up the continuing influence of the law enforcement components of government.

Armed with greater legislative authority, the FDA and NIMH, respectively, gave the drug industry nightmares (through the Investigational New Drug and New Drug Application regulations) and increased the acceptability of treatment, rehabilitation, and research in psychoactive substance use. Finally, the coalition between the Federal Trade Commission (FTC) and the newly established National Clearinghouse for Smoking and Health in the Public Health Service (PHS) made it clear to the tobacco industry that formidable challenges were ahead.

Examining consumption patterns of the era, a number of points require explanation. The 1964 report of the Surgeon General's Advisory Committee on Smoking and Health, the successful efforts of the FTC in requiring warnings on cigarette labels and in advertising, and the cessation of the distribution of free cigarettes by the Public Health Service (PHS), the Veterans Administration (VA), and the Department of Defense (DOD) were in part responsible for decreasing consumption of cigarettes. However, many observers attribute most of

the decline to normative reasons; smoking was increasingly labeled as annoying and tantamount to moral turpitude. Nevertheless, after a brief interlude of decreased consumption, to the delight of the tobacco industry and tobacco state Congressmen, cigarette smoking continued on its upward trend.

In regard to amphetamine, cocaine, LSD, and inhalant use, one factor stands above all others—law enforcement. It is undeniable that the psychedelic movement, personified by Timothy Leary, with the message of "turning-on" to "tune-out" was a significant phenomenon. However, law enforcement agencies, remembered for their unsubstantiated claims about marijuana use, severely aggravated the already widening credibility gap between youth and the "establishment." Because of the foregoing and the compulsion of enforcement agencies to publicize, LSD and glue sniffing enjoyed a wider popularity. Furthermore, the so-called "cracking down" on illicit amphetamine and barbiturate use prompted the rejuvenation of cocaine use.

Regarding heroin use, it will be remembered that racism, unemployment, and other socioeconomic restraints contributed to a pattern of use where heroin was found predominately in inner-city neighborhoods of black and Hispanic groups. Moreover, contrary to pre-1960 heroin use patterns, there was a greater frequency in female users and those dependent on drugs. Near the close of the sixth decade, heroin use had significantly extended to suburban America.[50] It is also clear that the birth of methadone maintenance and drug-free modalities was instrumental in consumption patterns. In fact, methadone maintenance brought a greater level of acceptance of heroin dependence to the medical community.

One of the most interesting developments, which had significant policy implications, to come out of the experience of heroin dependency during the 1960s was the greater acceptance of the influence of the physical and social setting on drug taking behavior. Two complex social experiments bring this point home. First, regarding the psychedelic drug explosion, drug psychosis, which initially was very common, practically disappeared due to the development of counterculture maxims or social sanctions promulgated by the very consumers of these substances. Secondly, prior to the arrival of US Forces, there had been virtually no heroin in Vietnam; however, due to their persistent pursuit of relief from the terrifying aspects of this unpopular war, many soldiers developed drug dependency.[51] Interestingly, many more who used heroin did not become dependent, those who did become dependent stopped at least temporarily to pass urine tests before returning to the States, and considerably fewer Vietnam veterans than had been anticipated became dependent upon arriving home.

In the last analysis, federal intervention was spurred by the anxiety of American society over the returning heroin-dependent Vietnam veterans and the unabated crime rate, often falsely attributed to drug use. Additionally President Nixon, publicly concerned with "crime on the streets" and privately interested in his own public image, urged passage of legislation with strong criminal justice undertones. Nevertheless, it was perfectly clear that by the end of the 1960s, federal policy was based on two priorities: (1) minimizing supply through interdiction and enforcement, and (2) curtailing demand through treatment and rehabilitation.

Clearly, the foregoing history was less than exhaustive. For example, the lack of an in-depth consideration of personalities is not meant to imply that few influential persons were instrumental in policy development. Quite the contrary, the contributions of many individuals were quite noteworthy. Nonetheless, the intent of the preceding was to demonstrate that drug-using behavior and the responses it elicits are dynamic, multifaceted phenomena which constantly change and cannot be understood apart from the sociocultural and historical contexts in which they occur.

CONCLUSIONS

In this regard, a number of conclusions can be drawn from the foregoing. Foremost among these is the fact that drug-seeking behavior has been a part of American life from its earliest existence. Unfortunately, certain factions of American society have used the oppression of other less endowed factions to obtain or maintain more influential positions in society. Secondly, although the health professions, including organized

medicine, have historically demonstrated justifiable concern in psychoactive substance use, there have also existed times in American history when professional behavior has encouraged, rather than discouraged, drug-seeking behavior. And lastly, the role of the federal government provides a final conclusion—unfortunately, a by-product of a fragmented approach to psychoactive substance use. Because economic and political considerations often outweigh public health issues, the federal response has, at times, resulted in increased consumption of the federally targeted substances or other substances which readily replace those which are targeted. In summary, many factors are operable in psychoactive substance use. As demonstrated, history often provides some sense of the influence of these factors, increasing the capability of effective planning.

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