History of Legal and Medical Roles in Narcotic Abuse in the U.S.

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WHEN the United States acceded to the United Nations' Single Convention on Narcotic Drugs on May 25, 1967, it reinforced the trend toward greater involvement of both government and medicine in the problem of narcotic abuse. How government and medicine will play their respective roles will continue to be developed—and doubtless debated—but for neither is there any lessening of responsibility in this international consensus (*1*).

Our accession to the new convention, following recent Federal, State, and local developments, makes it timely to review the historical pattern of action by government and medicine at these four levels in respect to narcotic abuse as a medical-social problem. Such history will not determine what the roles should be, but it is important as background to what they are and what they may become.

Contrary to some impressions, narcotic abuse was recognized as a medical-social problem in the United States long before the Harrison Act of 1914 (*2*). The problem had elements of ordinary vice, that is, a socially disapproved form of pleasure. It was also a medical problem, primarily that of self-medication with painkillers for either physical or emotional pain, contrary to the judgment of ethical physicians. As a vice, narcotic abuse was largely identified with opium smoking and opium dens, alien to American concepts of legitimate pleasure.

As a medical problem, addiction was prevalent among Civil War veterans who had been treated with morphine. Medication with opiates was also commonly practiced—and vigorously encouraged by the patent medicine industry—for almost any ailment, including alcoholism and drug addiction. Physicians were enlisted in the fight against nostrums and quackery. Suppression of vice and control of self-medication coalesced in legal controls against abuse of narcotic drugs (*3*).

State and local police measures were tried first, starting at least as early as 1885. A 1912 study concluded that "there are few if any subjects regarding which legislation is in a more chaotic condition than the laws designed to minimize the drug-habit evil" (*4*). This study quoted a report submitted in 1911 by the President to Congress (*5*).

> The enormous misuse of opium and other habit-forming drugs in the United States may be attributed to several causes—carelessness or ignorance on the part of the people; to ineffective State laws, as well as to the inability of States with good laws to protect themselves against the clandestine introduction of the drugs from neighboring or distant States, and therefore in a larger sense to the lack of control by the Federal Government of the importation, manufacture, and interstate traffic in them.

The U.S. Government had begun promoting international action and taking its own measures to control the world traffic in narcotics. President Theodore Roosevelt called an international meeting at Shanghai in 1908 to initiate joint action by interested governments (*3*). In 1909 Congress passed "An Act to prohibit the importation and use of opium for other than medicinal purposes." Congress did not define "medicinal purposes," but flatly excluded opium for smoking and subjected the importation of opium and opiates for medicinal purposes to regulation by the Secretary of the Treasury (*6*).

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The Hague Convention of 1912 established an international obligation to control domestic as well as foreign trade in opiates (*7*). The Harrison Act of 1914 (*2*) completed the basic framework of legal controls—international commitments, State and local police measures, and Federal law to fulfill international commitments and reinforce State and local measures. Government at all levels concentrated on legal controls, in accord with the contemporary view of the role of government.

This multiple structure—international, Federal, State, and local—is still the basic framework of policy and action in the field of narcotic abuse. At all jurisdictional levels there has been a growing emphasis on positive health measures, but in combination with legal controls. There is a corresponding need for understanding and adjustment among jurisdictional levels and between government and medicine.

International Action

It is perhaps symbolic that two of the three U.S. plenipotentiaries at the 1912 Hague conference were a bishop and a physician (*7*). The resulting convention went beyond control of international commerce and included obligations to control manufacture, domestic traffic, and use of opiates. A long series of supplementary international agreements followed and reinforced the Hague Convention of 1912 (*8*).

The United Nations' single convention is now superseding the 1912 convention and most of its successors (*8*). The new convention was adopted at a United Nations conference in 1961. The United States refused to sign for fear that the convention would weaken control of narcotic drugs by permitting additional countries to produce opium and by permitting governments to accede with reservations. But on March 8, 1967, President Johnson requested the Senate's advice and consent to accede for the United States on the grounds that the anticipated weaknesses had not proved serious and that accession would advance our interest in drug control.

The Senate Foreign Relations Committee held hearings at which the Departments of State and Treasury supported the new convention with extensive analysis and documentation. No one appeared in opposition. The committee reported favorably on May 3, 1967, the Senate gave its advice and consent on May 8, and the formal accession with no reservations was accomplished May 25 (*1, 8, 9*).

The single convention is a long, complex, and largely technical document. Although it has the features which the U.S. Government originally considered as weakening, it continues essentially the previous international controls restricting the production, distribution, and use of narcotic drugs to medical and scientific purposes. It includes more obligations for acceding governments, extends the coverage of international commitments to more drugs, including marijuana and its raw materials, and provides for adding new drugs to the control lists. Some provisions are mandatory, some are recommendations, and some are qualified by such clauses as "if the Parties deem these measures necessary or desirable." With all its flexibility, however, the convention represents a high degree of international policymaking in domestic as well as international aspects of drug abuse.

It also combines legal controls with positive health measures. On one hand, subject to constitutional limitations, each government is obligated to adopt measures to assure penal sanctions for intentional offenses which are contrary to the provisions of the convention (including possession and purchase). On the other hand, a prominent new feature of the convention is article 38, which provides the following.

Treatment of Drug Addicts

1. The Parties shall give special attention to the provision of facilities for the medical treatment, care and rehabilitation of drug addicts.

2. If a Party has a serious problem of drug addiction and its economic resources permit, it is desirable that it establish adequate facilities for the effective treatment of drug addicts.

Federal Action

The Harrison Act of 1914, implementing the Hague Convention of 1912, was a tax act with a clear regulatory purpose upheld by the Supreme Court (*10*). With the help of the physician-plenipotentiary from the Hague conference (*11*), the authors spelled out requirements and prohibitions appropriate to limit the importation, production, sale, and use of opiates to medicinal and scientific purposes. They exempted from the act's prohibitions, although

not from all requirements, the use of narcotic drugs by a registered physician in the course of his professional practice only (*2*).

Since the Harrison Act, Congress has broadened its concept of the constitutional base for Federal legislation regarding narcotics well beyond the taxing power. In stating the basis for the Narcotics Manufacturing Act of 1960, Congress included the international obligations of the United States and the promotion of public health, safety, and welfare, as well as the regulation of interstate and foreign commerce (*12*). Criminal sanctions have been provided as necessary and proper in the exercise of these powers, but since these sanctions rest on the same constitutional basis as "*all* laws which shall be necessary and proper for carrying into Execution the foregoing Powers," Congress has not been limited to criminal sanctions.

The Public Health Service program for narcotic addiction was initiated by Public Law 672 of the 70th Congress, enacted January 19, 1929. Under this law, codified in the Public Health Service Act in 1944, the program included four basic elements.

1. Treatment and rehabilitation of narcotic drug addicts who are convicted of Federal offenses.

2. Prevention of Federal narcotics offenses by treatment and rehabilitation of voluntary patients, as well as those already convicted of Federal offenses.

3. Encouraging and assisting States and their constituent communities to provide adequate facilities and methods for the care of their narcotic addicts with the benefit of Federal cooperation and experience.

4. Research and training in the causes, diagnosis, treatment, control, and prevention of narcotic drug addiction.

The Public Health Service hospitals at Lexington, Ky., opened in 1935, and at Fort Worth, Tex., opened in 1938, have provided treatment and rehabilitation services for prisoners, probationers, and voluntary patients in an institution "less prison-like in appearance than most prisons and more prison-like than most hospitals" (*13*). Voluntary patients, however, could and did leave when they pleased, following a Federal district court decision that statutory provisions for their treatment for the time necessary "to effect a cure" must be interpreted, in order to avoid constitutional questions, as not authorizing involuntary detention for treatment (*14*).

Research and training activities were also carried on, and consultative services were provided to State and local agencies to assist them in the prevention and treatment of addiction. There may have been an unintended side effect, establishing a national image of Lexington and Fort Worth as the primary places for treatment of narcotic addicts, despite the purpose and policy of encouraging States and communities to develop their own programs. Both hospitals are now being converted into research centers by the National Institute of Mental Health, and the Federal Bureau of Prisons, whose medical services are provided by the Public Health Service, is developing a treatment program for its addict-prisoners.

An Institute on New Developments in the Rehabilitation of the Narcotic Addict, held at Fort Worth, Tex., February 1966 (*15*), described innovations in the Federal treatment programs preceding the Narcotic Addict Rehabilitation Act of 1966.

Aside from the Public Health Service program, Federal emphasis in the field of narcotic abuse from 1914 to 1966 was on rigorous enforcement of the existing Federal laws with increasing penalties and less opportunity for probation or parole, additional legislation to tighten controls and to extend similar controls to synthetic narcotics and marijuana, encouragement of State legislation such as the Uniform Narcotic Drug Act, which was enacted by Congress for the District of Columbia in 1938, and cooperation with State and local enforcement agencies (*16*).

During this period there was extensive litigation and controversy over the practical interpretation of the Federal law's exemption of the use of narcotics by a physician "in the course of his professional practice only," either by administering or dispensing them "to a patient" or by issuing a written "prescription." Legal issues turned on the meaning of words such as those quoted; behind the legal issues were conflicting views of the legitimate scope of governmental—especially Federal—control of physicians' conduct.

When a physician sold 4,000 narcotics orders in 11 months to anyone paying 50 cents each, the U.S. Supreme Court held that "to call such an order . . . a physician's prescription would be so plain a perversion of meaning that no discussion of the subject is required" (*17*). When another physician was convicted on a very different set of facts, the Supreme Court said, "It [the Harrison Act] says nothing of 'addicts' and does not undertake to prescribe methods for their medical treatment. They are diseased and proper subjects for such treatment, and we cannot possibly conclude that a physician acted improperly or unwisely or for other than medical purpose solely because he has dispensed to one of them, in the ordinary course and in good faith, four small tablets of morphine or cocaine for relief of conditions incident to addiction. What constitutes bona fide medical practice must be determined upon consideration of evidence and attending circumstances" (*18*).

Between these polar decisions there was enough area of controversy and uncertainty to lead the President's Advisory Commission on Narcotic and Drug Abuse (the Prettyman Commission) in 1963 to recommend "that Federal regulations be amended to reflect the general principle that the definition of legitimate medical use of narcotic drugs and legitimate medical treatment of a narcotic addict are primarily to be determined by the medical profession" (*19*).

While retaining the pertinent language of the Treasury regulations, the Bureau of Narcotics in March 1966 issued a revised pamphlet, "Prescribing and Dispensing of Narcotics Under the Harrison Narcotic Law" with a "Dear Doctor" statement of its purpose "to generate interest in treating and curing addiction and to make clear that the policy of the U.S. Government does not restrict physicians who desire to treat narcotic drug addicts in the course of ethical practice of medicine" (*20*).

The pamphlet cites court decisions, but is mainly a compilation of statements from the American Medical Association and the National Research Council. The latest and most extensive of these is the report of the association's Council on Mental Health and the National Academy of Sciences–National Research Council's Committee on Drug Addiction and Narcotics, issued in June 1963. This report reviews current medical opinion in recognition of the fact that "expressions of prevailing medical opinion have a profound impact not only on medical practice but on regulations, laws, and courts, and that it is the duty of the medical profession to review its expressed opinions regularly in order to assure their current validity." A revision of the report has since been published in an effort to maintain a current code of ethical medical practice in respect to narcotics and narcotic addiction (*21*).

A major landmark at the Federal level since 1914 is the Narcotic Addict Rehabilitation Act of 1966 (NARA) with its accompanying declaration of policy in favor of civil commitment for treatment in lieu of prosecution or sentencing for "certain persons charged with or convicted of violating Federal criminal laws, who are determined to be addicted to narcotic drugs, and likely to be rehabilitated through treatment . . ." (*22*). Congress further declared its policy and provided legal procedures in title III of the NARA for what had previously been left entirely to the States, namely civil commitment for treatment of narcotic addicts not charged with any criminal offense.

Implementation of the NARA is just beginning, but it already illustrates the complex of interrelated roles of government and medicine at international, Federal, State, and local levels. The law conforms to the basic pattern of the new international convention in leaving undiminished the Federal legal controls on the production, distribution, and use of narcotics, but gives "special attention" to the "treatment, care and rehabilitation of drug addicts." Unlike article 38 of the UN convention the NARA emphasizes treatment programs more than facilities and defines treatment much more inclusively than might be understood from the term "medical treatment."

While the legislation leading to the NARA was described by the U.S. Attorney General as "a first step toward disentangling medical and criminal elements in the knot of problems we call drug addiction" (*23*), the coercive role of government is continued through civil commitment of addicts who are either not charged with any crime or are charged but civilly committed in lieu of criminal prosecution; addicts con-

victed of a Federal crime are sentenced "to commitment for treatment."

The NARA is a Federal innovation, but the Federal role is clearly seen as complementary to that of States and local communities and nongovernmental agencies. It provides for "utilizing all available resources of local, public and private agencies," and for assisting "States and municipalities in developing treatment programs and facilities." It authorizes special grants to States, political subdivisions of States, and private organizations and institutions to develop and evaluate programs, and authorizes cooperative arrangements for treatment centers and facilities.

An even broader but noncoercive Federal approach to narcotics abuse is represented in the programs for community mental health centers (*24*), for comprehensive health services in "areas having high concentrations of poverty and a marked inadequacy of health services" (*25*), and for the Federal-State-local "Partnership for Health" (*26*). In all these programs abuse of narcotics is recognized as a specific problem, but in the first, in the context of community mental health, and in the second and third, in the context of comprehensive health services as part of total community life.

Under the Economic Opportunity Amendments of 1966 about $12 million were provided for community addiction programs as part of the comprehensive health services for poverty areas. Also under this act, the legal services program provides a means of advising addicts and their families of available treatment programs which may be a more hopeful alternative to present or eventual prosecution for crime (*25*).

Federal policy as represented by these several approaches has been described by some as ambivalent and by others as balanced in seeking the objectives of public safety and a maximum opportunity for addicts to achieve a normal life (*15*).

State and Local Action

State and local controls against narcotic abuse may have been chaotic in 1912, but with growing Federal influence and the recommendations of the Commissioners on Uniform State Laws they became largely standardized. Most included prohibitions against any unauthorized manufacture, sale (generally including gifts or other transfers), or possession of narcotic drugs (including cannabis or marijuana by special definition) and with increasingly severe penalties for violations (*16*).

Treatment of narcotic addicts was specifically authorized by State law at least as early as 1874 in Connecticut. In 1909 New York passed a law for civil commitment of addicts on their voluntary application, but failed to provide any facilities for treatment. Addicts, with alcoholics, have been low on the priority list for even such treatment as the States provided for mental disorders generally. California did authorize a State hospital especially for drug addicts in 1927. When a survey was made for the U.S. Senate in 1956, numerous State laws for civil commitment and treatment of narcotic addicts had been enacted but few States had facilities to implement them and such treatment as there was was mainly institutional and custodial (*27*).

While published debate over legal restrictions on what physicians may do with addicts has centered on the Federal law, similar questions arise under State laws. State jurisdiction over medical practice of course differs from Federal jurisdiction, but there is still the underlying problem of defining legitimate governmental control of physicians' conduct. The Uniform Narcotic Drug Act is similar to the Federal law in permitting a physician to prescribe, administer, or dispense narcotics "in good faith and in the course of his professional practice only." California, however, has imposed detailed specifications for the treatment of addicts by physicians, ranging from the place of treatment to the dosage of narcotics to reports of progress and treatment (*16*).

Several States made addiction itself a crime, although it never has been under the Federal law. This led to a landmark Supreme Court decision in 1962, holding it to be unconstitutional to punish addiction, a disease, as a crime. But other measures against narcotic abuse were not directly affected by the decision, and in fact were encouraged by the Court's discussion of the problem. The Court said (*28*):

> Such regulation, it can be assumed, could take a variety of valid forms. A State might impose criminal sanctions, for example, against the unauthorized manufacture, prescription, sale, purchase, or possession of

narcotics within its borders. In the interest of discouraging the violation of such laws, or in the interest of the general health or welfare of its inhabitants, a State might establish a program of compulsory treatment for those addicted to narcotics. Such a program of treatment might require periods of involuntary confinement. And penal sanctions might be imposed for failure to comply with established compulsory treatment procedures. Or a State might choose to attack the evils of narcotics traffic on broader fronts also—through public health education, for example, or by efforts to ameliorate the economic and social conditions under which those evils might be thought to flourish.

Major recent developments in State laws indicate an approach similar to that of the Supreme Court.

1. Commitment for treatment, with both institutional and community care, for addicts charged with a criminal offense who elect treatment in lieu of prosecution and are considered suitable for treatment—as in New York since 1962 and under title I of the NARA (*15*, *22*).

2. Involuntary commitment for both institutional and community care of addicts not charged with any crime—as in New York (*29*) beginning April 1, 1967, in California, and under title III of the NARA.

3. Commitment of selected addicts for treatment (with or without their consent) after conviction of crime. This is a recent development in program rather than in principle and varies with program development. Its major innovation is the combination of institutional and community care—as in California and under title II of the NARA (*15*, *22*).

Such laws, in providing for both hospital and posthospital care, cause at least a partial shift of emphasis from more or less isolated facilities to community treatment. At least there is a significant change from the situation described by a New York State legislative committee as recently as 1959 when it reported, "Narcotics addiction represents perhaps the one major mental health disease entity which is now completely ignored by community mental health resources" (*30*). This move toward community care is stimulated by the NARA, the community mental health centers program, and the comprehensive health services program under the Economic Opportunity Act. It has also been recommended at the international level by experts of the World Health Organization, although the new UN convention is silent on the subject.

The distinction between Federal programs and State or local programs for the prevention and treatment of narcotic addiction becomes a distinction of roles rather than of programs as the programs themselves become joint enterprises of Federal, State, and local agencies, with both governmental and nongovernmental participation. The history of this trend remains to be made, as well as to be written. Many of the innovations of the last few years in separate Federal, State, and local programs and in community programs with Federal and State support are described in the report of the 1966 Institute on New Developments in the Rehabilitation of the Narcotic Addict (*15*).

Beyond the direct operation of community programs by public and private agencies, there is whatever stimulative effect such laws and programs may have on the treatment of addicts in the private practice of medicine, with the encouragement of the Bureau of Narcotics "to treat narcotic drug addicts in the course of ethical practice of medicine" (*20*). If practicing physicians are more pluralistic than law enforcement agencies in their views of what is ethical in the treatment of addicts, channels of expression are available to carry on the continuing review recommended by the committees of the American Medical Association and the National Academy of Sciences-National Research Council.

Conclusions

The history of narcotic abuse as a medical-social problem in the United States shows a complex of legal and medical roles and of policy development at international, Federal, State, and local levels. It extends from early State and local, public and professional, efforts to control narcotic abuse to such recent developments as United States accession to the United Nations single convention, the Federal Narcotic Addict Rehabilitation Act of 1966, new State laws and programs for treatment as well as legal controls, and the application of broader government approaches through the community mental health centers program and the comprehensive health services program for poverty areas. Related to all such developments is the role of medicine, both public and private, in providing professional services, forming public policy, and de-

fining the relation between government and medicine. Public health agencies may occupy a strategic position, at least for communications, in this complex of government and medicine and interjurisdictional relations.

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