White, W. (2004). History of drug problems and drug policies in America. In R. Coombs (Ed.), *Addiction counseling review: Preparing for comprehensive certification exams*. Lahaska Press, pp.81-104.

History of Drug Policy, Treatment, and Recovery

William L. White, M.A.

T/F questions

___1. Alcoholics Anonymous was the first and the fastest growing alcoholic mutual aid society in the world.
___2. America's "discovery of addiction" in the early twentieth century led to the "noble experiment" of alcohol prohibition.
___3. Men, women and children consumed alcohol every day in Colonial America.
___4. Most people addicted to narcotics in the nineteenth century were provided narcotics by physicians or ingested narcotics to self-treat medical conditions.
___5. Opiate addiction in American during the nineteenth century was primarily a problem experienced by the Chinese.
___6. The disease concept of alcoholism was first introduced by E.M. Jellinek.
___7. Maintaining opiate addicts on medically monitored, daily doses of narcotics was first introduced as a treatment for addiction in the 1960s.
___8. Methadone maintenance was pioneered by Drs. Dole, Nyswander and Kreek.
___9. The only federally-funded treatment resources for narcotic addiction treatment in the 1930s and 1940s were the public health hospitals ("narcotics farms") in Lexington, Kentucky and Fort Worth, Texas.
___10. A major milestone in the history of addiction treatment was the birth of the therapeutic community in the late 1950s.
___11. The anti-medication bias in the field of addiction treatment is historically rooted in the number of such medications that have later been found to have a high potential for misuse.
___12. The President most associated with pushing prevention and treatment as a national drug control policy was Richard Nixon.
___13. The American Association for the Study and Cure of Inebriety was founded upon the belief that inebriety was a bad habit rather than a disease.
___14. A major factor in the explosive growth of addiction treatment between 1975 and 1985 was the expansion of insurance benefits to treat alcoholism and other addictions.

___15. The most influential document in the rise of the modern alcoholism treatment system was the 1967 report of the Cooperative Commission on the Study of Alcoholism.

Introduction

The purpose of this chapter is to offer you a brief overview of the history of: 1) alcohol and drug-related problems, 2) recovery mutual aid societies, 3) addiction treatment, and 4) addiction-related laws and social policies in America. The histories of mutual aid and treatment, unless otherwise noted, are drawn from *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. The history of alcohol, tobacco and other drug-related laws and social policies is drawn primarily from the published works of Drs. David Musto and David Courtwright.

History is about chronology and context: it is about how events influence one another to shape the present and future. The importance of studying the roots of our field is reflected in the words of Lily Tomlin who once noted, "Maybe if we listened, history wouldn't have to keep repeating itself."

When did alcohol and other drug problems begin in the United States?

Alcohol usage was pervasive in colonial America. Men, women and children consumed alcoholic beverages every day and throughout the day. The tavern was the center of colonial life. America's first colleges had breweries on campus for the convenience of faculty and students. In spite of the ever-presence of alcohol, drunken comportment was highly stigmatized, and there was no recognition of alcoholism as we know it today. Isolated problems of chronic drunkenness were viewed as a moral or criminal matter rather than a medical or public health problem.

Dramatic changes in drinking patterns following the Revolutionary War changed the conception of alcohol from the "Good Creature of God" to "Demon Rum." Between 1780 and 1830, annual per capita alcohol consumption in America rose from 2 ½ gallons to more than 7 gallons, and drinking preferences shifted from fermented beverages such as cider and beer to rum and whiskey (Rorabaugh, 1979). Rising alcohol-related problems during this period led to the "discovery of addiction" (Levine, 1978).

Alcohol was not the only drug generating public concern in the nineteenth century. Increased consumption of opium, morphine, cocaine, chloral, ether and chloroform via medical treatment or liberal self-treatment with patent medicines generated new patterns of addiction and growing civic alarm. The dominant profile of the opiate addict during this period was an educated, affluent, middle-aged white woman (particularly in the South).

New technologies that heightened drug potency, expanded the methods of drug ingestion, increased drug availability and unleashed unprecedented promotional forces played a significant role in the rise of these new patterns of addiction.

Figure 1: Technology and the Rise of American Drug Problems

Technological Innovation	Significance
Increased Distillation	Increased Alcohol Addiction (shift from fermented beverages to distilled spirits)
Isolation of Plant Alkaloids	Increased Morphine & Cocaine Addiction
Hypodermic Syringe	Increased Opiate & Cocaine Addiction
Newspaper Advertising	Promotion of Alcohol-, Opiate-, and Cocaine-based Patent Medicines
The Wooden Match; Cigarette Rolling Machine	Increased Nicotine Addiction

In 1800, America had no conception of addiction; in 1900, she had witnessed a growing psychoactive drug menu, experienced her first anti-drug campaigns, passed numerous local and state anti-drug laws, and generated a significant body of literature about addiction—all of which were about to culminate in the prohibition of alcohol, tobacco and the non-medical use of opiates and cocaine.

When did the first medical conceptions and responses to addiction begin?

America's revolution in consciousness about alcohol was engineered by her most prominent social activist, her most eminent physician, and a leading clergyman. In 1774, Anthony Benezet, a Quaker social reformer, published a stinging indictment of alcohol entitled *Mighty Destroyer Displayed.* He christened alcohol a "bewitching poison and spoke of "unhappy dram drinkers . . . bound in slavery" who had lost voluntary control of their decision to drink or not drink. Dr. Benjamin Rush followed Benezet's writings with a series of pamphlets culminating

in his 1784 *Inquiry into the Effects of Ardent Spirits on the Human Mind and Body.* Rush suggested that chronic drunkenness was a "disease induced by a vice," described the progressive nature and medical consequences of this disease, and suggested that chronic drunkenness be viewed as a medical rather than a moral problem. Perhaps most importantly, Rush argued that it was the responsibility of physicians to treat this disorder, and suggested several methods (ranging from religious conversion to aversive conditioning) through which chronic drunkards could be cured. By 1790, Rush was calling for the creation of a special hospital for inebriates (a "Sober House"). The third influence on America's changing conception of alcohol and chronic drunkenness was the Reverend Lyman Beecher who in 1825 delivered his widely read *Six Sermons on the Nature, Occasion, Signs, and Remedy of Intemperance*. Beecher spoke of the drunkard as being "addicted to sin," characterized intemperance as an accelerating disease, meticulously detailed its early stages, and argued that complete and enduring abstinence was the only method of prevention and cure.

By the late 1820s, the American Temperance Movement was underway, and there was a growing trend toward the medicalization of alcohol and other drug problems. Between 1828-1832, two prominent medical directors of state insane asylums—Drs. Eli Todd and Samuel Woodward—added their support for the creation of special institutions for the care of the inebriate.

In the transition from the 18th to the 19th century, a vanguard of American physicians and social reformers redefined drunkenness as a medical problem, encouraged physicians to treat inebriety in their medical practice, and called for the creation of specialized institutions. Inherent in this shift were the core elements of an addiction disease concept: hereditary predisposition, drug toxicity, morbid appetite (craving), pharmacological tolerance and progression, loss of volitional control of drug intake, and the pathophysiology of chronic alcohol, opiate, or cocaine consumption. This early movement reached fruition in the work of Swedish physician Magnus Huss, who in 1849 introduced the term "alcoholism" to characterize the a cluster of symptoms "formed in such a particular way that they merit being designated and described as a definite disease." While many new terms were suggested for this phenomenon, *inebriety* was the preferred term whose meaning is analogous to the term addiction. Texts of the day included chapters on alcohol inebriety, opium inebriety, cocaine inebriety, and inebriety from coffee and tea. The term *alcoholism*, whose use is presently diminishing, did not achieve professional or cultural prominence until the early decades of the twentieth century (White, 2002b).

When did addiction treatment begin in the United States and what types of treatment were first available?

By the 1830s, the growing Temperance Movement was experimenting with "rescue work" with inebriates. Several temperance societies concluded that inebriates needed more than pledge-signing and attendance at temperance meetings to sustain sobriety. To buttress such sobriety, inebriate homes were created that viewed recovery from alcoholism as a process of moral reformation and immersion in sober fellowship. The first of these homes—the Washingtonian Homes in Boston and Chicago—opened in 1857 and 1863. The inebriate homes utilized short, voluntary stays followed by affiliation with local recovery support groups.

The call for specialized medical facilities resulted in another institution—the medically-directed inebriate asylum that relied on legal coercion (multi-year legal commitments) and emphasized physical and psychological methods of treatment (drug therapies, hydrotherapy, hypnotherapy). The first of these facilities—the New York State Inebriate Asylum—opened in 1864 under the leadership of Dr. Joseph Edward Turner.

In 1870, the leaders of several inebriate homes and asylums met in New York City to found the American Association for the Cure of Inebriety—the first professional association of addiction treatment providers. In 1876, the Association began publishing the *Quarterly Journal of Inebriety*, the first addiction-themed specialty journal. It was edited by Dr. T.D. Crothers for the life of its publication (1876-1914).

Figure 2: Bylaws of the American Association for the Study and Cure of Inebriety (1870)
1. Intemperance is a disease. *2. It is curable in the same sense that other diseases are.* *3. Its primary cause is a constitutional susceptibility to the alcoholic impression.* *4. This constitutional tendency may be either inherited or acquired.*

As inebriate homes and asylums achieved greater visibility, they faced competition from several sources, including private, proprietary (profit-making) addiction cure institutes. The most famous of these, the Keeley Institute, was founded in 1879 with the proclamation by Dr. Leslie Keeley that "Drunkenness is a disease and I can cure it." Dr. Keeley went on to franchise more than 120 Keeley Institutes that used his Double Bi-Chloride of Gold Cures for Drunkenness and the

Opium and Tobacco Habits.

There were also bottled home cures for the "alcohol, tobacco and drug habits." These aggressively promoted products were the brainchild of the addiction cure institutes and the same patent medicine industry that was doping the nation. These alleged addiction cures continued until an exposé in 1905 revealed that most of these products contained high dosages of morphine, cocaine, alcohol and cannabis. The morphine addiction cures that promised consumers a product containing no narcotic or narcotic substitute nearly all contained high dosages of morphine.

Institutional intervention into chronic alcoholism was also provided by religiously oriented urban rescue missions and rural inebriate colonies. The former were pioneered by Jerry McAuley who opened the Water Street Mission in 1872 after his own religiously inspired recovery from alcoholism. Such rescue work with late-stage alcoholics was later institutionalized within the programs of the Salvation Army.

The final institution that bore an increasing brunt of responsibility for the care of the chronic inebriate was the urban city hospital. Bellevue Hospital in New York City opened an inebriate ward in 1879 and saw its alcoholism admissions increase from 4,190 in 1895 to more than 11,000 in 1910.

Figure 3: Professionalized Treatment of Addiction in the Nineteenth Century

Treatment/Care of Inebriates	Representative institution/product	Founding date
Inebriate Homes	Washingtonian Home -Boston -Chicago Martha Washington Home (first women's facility)	 1857 1863 1869
Inebriate Asylums	New York State Inebriate Asylum	1864
For-Profit Addiction Cure Institutes	Keeley Institutes Gatlin Institutes Neal Institutes	1879

Bottled/Boxed Addiction Cures	Hay-Litchfield Antidote Knight's Tonic for Inebriates Collin's Painless Opium Antidote	1868 1870s 1880s
Urban Missions & Inebriate Colonies	Water Street Mission Keswick Colony of Mercy	1872 1897
City Hospital Inebriate Wards	Bellevue Hospital—New York City	1879

It should be noted that nearly all of these institutions—particularly the inebriate asylums and addiction cure institutes—treated addictions to all drug addictions, including cocaine addiction. There were facilities like Dr. Jansen Mattison's Brooklyn Home for Habitues (opened in 1891) which specialized in the treatment or morphine and cocaine addiction.

What happened to the hundreds of treatment programs that existed in the 19th century?

Between 1900 and 1920 most of the addiction treatment institutions that had been founded in the second half of the nineteenth century closed. This virtual collapse of America's first network of addiction treatment programs was caused by multiple factors: 1) exposés of ethical abuses related to the field's business and clinical practices, 2) ideological schisms within the field, 3) absence of scientific studies validating the effectiveness of treatment, 4) loss of the field's leadership via aging and death, 5) unexpected economic downturns that deprived the field of philanthropic and governmental support, and 6) growing cultural pessimism about the prospects of permanent recovery from alcohol and other drug problems.

The rise of therapeutic pessimism led to a bold new vision for resolving these problems: let those currently addicted to alcohol and other drugs die off and prevent the creation of a new generation of addicts through temperance education, the legal prohibition of alcohol and tobacco, and legal control of the non-medical use of opiates and cocaine.

On the heels of this change in public attitudes came a shift in cultural ownership of alcohol and other drug problems. As specialized addiction treatment programs closed, people with severe and prolonged alcohol and other drug problems were shuttled into the "foul wards" of urban community hospitals, the back wards of aging state insane asylums, and sentenced to rural inebriate penal colonies.

It was in this climate of disregard that those addicted to alcohol and other

drugs suffered iatrogenic insults (treatment-caused injuries): mandatory sterilization, serum therapy (a procedure involving blistering the skin, withdrawing serum from the blisters and then re-injecting it as an alleged aid in withdrawal), and bromide therapy (anesthesia-aided detoxification that was lauded in spite of its high mortality rate). Over the years, alcoholics and addicts were subjected to whatever prevailing techniques dominated the field of psychiatry, from the indiscriminate application of chemical and electroconvulsive therapies, to psychosurgery, and to drug therapies that later proved to have significant potential for misuse, e.g., LSD, barbiturates, amphetamines and a wide variety of tranquilizing and anti-anxiety agents. Much of the lingering anti-medication bias in the addiction treatment field stems reflects the shadow of this history.

The few pockets of hope for the addicted during the opening decades of the twentieth century were the remaining specialty programs, a new generation of private sanatoria and hospitals (e.g., the Charles B. Towns Hospital for the Treatment of Alcoholic and Drug Addictions in New York City that provided discrete drying out for the rich), and a clinic model of outpatient counseling. The clinic model was pioneered within the Emmanuel Church of Boston (1906) and utilized a unique program of lay therapy that brought individuals in recovery like Courtenay Baylor, Francis Chambers and Richard Peabody into the role of lay alcoholism psychotherapists. These lay therapists were the precursor to today's addiction counselor. The Emmanuel Clinic also organized its own mutual aid fellowship (the Jacoby Club) for those it treated.

When were the first recovery support groups founded in the U.S.?

Recovery mutual aid societies have a very long history in the United States. The earliest of these societies grew out of Native American religious and cultural revitalization movements. Native American recovery "circles" date from the 1730s and were particularly vibrant during the nineteenth century. Some of the most prominent leaders of these movements included Wangomend, the Delaware Prophets (Papoonan, Neolin), the Kickapoo Prophet (Kenekuk), the Shawnee Prophet (Tenskwatawa) and Handsome Lake (Ganioda'yo).

By the 1830s, Euro-American alcoholics were seeking sober refuge within local temperance societies, but it wasn't until the Washingtonian Movement of 1840 that Euro-American alcoholics banded together in large numbers for sobriety-based mutual support. The Washingtonians rapidly grew to a membership of more than 400,000 and then collapsed, with many recently sobered alcoholics moving underground via the creation of sobriety-based Fraternal Temperance Societies. John Gough and John Hawkins were among the most prominent Washingtonian

speakers/organizers of this period. They spent most of their adult lives organizing local recovery support groups, providing personal consultations to alcoholics and their family members and maintaining a prolific correspondence with people seeking or in recovery. When the Fraternal Temperance Societies were torn with political conflict or lost their service ethic to the still-suffering alcoholic, they were replaced by the Ribbon Reform Clubs and other local sobriety-based fellowships such as the Drunkard's Club in New York City. There were also alcoholic mutual aid societies that sprang up within the inebriate homes, asylums and addiction cure institutes. The most prominent of the early recovery mutual aid societies are displayed in table Figure 4 (White, 2001a).

Figure 4: 18th-19th Century Recovery Mutual Aid Societies

Native American Religious/Cultural
Revitalization Movements (1730s-present)
Washingtonian Movement (1840)
Fraternal Temperance Societies (mid-1840s)
Ribbon Reform Clubs (1870s)
The Drunkard's Club (early 1870s)
Institutional Support Groups
—Ollapod Club (1864-1868)
—Godwin Association (1872)
—Keeley Leagues (1891)
Business Men's Moderation Society (1879)

The nineteenth century mutual aid societies collapsed in tandem with the inebriate homes and asylum. Only a few local recovery support fellowships (e.g., the Jacoby Club in Boston) filled the void between this collapse and the founding of Alcoholics Anonymous (A.A.) in 1935. A.A. is the standard by which all other mutual aid groups are evaluated due to its size (2.2 million members and more than 100,000 groups; 1.1 million members in the United States), its geographical dispersion (more than 175 countries) and its longevity (more than 65 years) (http://www.alcoholics-anonymous.org). The last half of the twentieth century witnessed growing varieties of A.A. experience reflected in the growth of specialty groups (e.g., women, young people, newcomers, old-timers, gay and lesbian meetings) as well as religious (the Calix Society; Jewish Alcoholics, Codependents and Significant Others—JACS) and non-religious (A.A. for Atheists and Agnostics) adjuncts to A.A. The A.A. program has been adapted for family members (Al-Anon), for persons addicted to drugs other than alcohol (Narcotics

Anonymous, Cocaine Anonymous), for persons experiencing co-occurring disorders (Dual Disorders Anonymous, Dual Recovery Anonymous), and for nearly every other imaginable human problem. Also evident are a growing number of secular alternatives to A.A. (Women for Sobriety, Secular Organization for Sobriety, Rational Recovery, SMART Recovery, LifeRing Secular Recovery, and Moderation Management (White, in press) (See Figure 5).

Figure 5: 20th-21st Century Recovery Mutual Aid Societies

Jacoby Club (1909)
United Order of Ex-Boozers (1914)
Alcoholics Anonymous (1935)
—Calix Society (1949)
—JACS (1979)
Alcoholics Victorious (1948)
Narcotics Anonymous (1947/1953)
Al-Anon (1951)
Women for Sobriety (1975)
Cocaine Anonymous (1982)
Dual Disorders Anonymous-1982
Secular Organization for Sobriety (1985)
Rational Recovery (1986)
Dual Recovery Anonymous-1989
Moderation Management (1993)
SMART Recovery (1994)
LifeRing Secular Recovery (1999)

How have policies and laws toward alcohol, tobacco and other drugs evolved over the past century?

By 1850, the American temperance movement had shifted its strategy from promoting the moderate use of fermented alcohol to promoting total abstinence from all alcoholic beverages and advocating the legal prohibition of the sale of alcohol. Experiments with local and state prohibition led to a drive for national prohibition, ratification of the Eighteenth Amendment to the Constitution, and passage of the Volstead Act (the enforcement provisions of prohibition). National prohibition was inaugurated in 1919 and successfully reduced alcohol-related problems during the early twenties. Alcohol-related problems rose in the late twenties as the illicit alcohol trade increased. By the late 1920s, there was growing

sentiment that the “noble experiment” of prohibition was failing. National prohibition came to an end in 1933 with the ratification of the Twenty-first Amendment to the Constitution.

The first anti-narcotics ordinance in the United States, a local ordinance passed in 1875 in San Francisco, was aimed at suppressing the Chinese opium dens. This was followed by other municipal ordinances and state laws aimed at the control of opium, morphine and cocaine. What was emerging by the end of the nineteenth century was a policy of having physicians serve as gatekeepers for the legitimate distribution of these drugs (prescription laws) and the criminalization of the non-medical sale of these substances.

The first federal law addressing psychoactive drugs other than alcohol and tobacco was the Pure Food and Drug Act of 1906. This act, which required that all medicines containing alcohol, opiates or cocaine be so labeled, had two effects. It quickly lowered rates of narcotic addiction and it banished most of the bottled addiction cure frauds. The most historically significant piece of drug legislation—the Harrison Anti-Narcotic Act—was passed by Congress in 1914. This federal act required that opiates and cocaine be sold only by a physician or a pharmacist authorized by a physician.

Between 1914-1919, a series of Supreme Court decisions interpreted the Harrison Act. In the most important of these decisions (Webb vs. the United States), the Supreme Court declared in 1919 that for a physician to maintain an addict on his or her customary dose was not in “good faith” medical practice under the Harrison Act and was an indictable offense. By one account, twenty-five thousand physicians were indicted for violation of the Harrison act between 1919 and 1935 and 2,500 went to jail.

In 1912**,** Dr. Charles Terry, director of public health in Jacksonville, Florida, opened a clinic to treat opiate addicts. This marked the beginning of clinic-directed detoxification and maintenance of narcotic addicts. Following the Webb v. United States decision, physicians in 44 communities established morphine maintenance clinics, all of which were closed by 1924 under threat of legal indictment. Many of these physicians become the harshest critics of the Harrison Act and this new era of drug repression and federal involvement in medical practice. In the same year of the Webb v. U.S. decision, the France Bill, which would have provided federal support for physician-directed, community-based treatment for addicts, came before Congress, but failed to pass. Between 1924 and 1935, treatment for narcotic addiction other than detoxification was almost non-existent.

Cannabis (marijuana) was included in the first draft of the Harrison Act, but was deleted under pressure from physicians and pharmacists on the grounds that

there were many legitimate medical uses for cannabis and that its non-medical abuse was rare. An anti-marijuana campaign in the late 1920s and early 1930s led to passage of the Marihuana Tax Act of 1937 that designated cannabis a narcotic with penalties for its possession and sale similar to those for heroin.

There was also a well-organized anti-tobacco campaign of the late nineteenth and early twentieth centuries that successfully banned the sale of tobacco in many states. Following repeal of alcohol prohibition and the collapse of support for anti-tobacco legislation in the 1930s, alcohol and tobacco became highly promoted and celebrated drugs in American society, while the non-medical use of opiates, cocaine, and cannabis will become further stigmatized and criminalized via accelerating legal penalties. The harshness of new anti-drug measures in the 1950s set the stage for the reform movements in the 1960s and 1970s.

Figure 6: Early Milestones in American Narcotic Control Policy

Year	Event	Significance
1906	Pure Food and Drug Act	Requires labeled of medicines containing opium, cocaine, cannabis and chloral
1909	Shanghai Opium Commission	First international discussion of drug control
1909	The Smoking Opium Exclusion Act	Prohibits importation of opium for smoking
1912	The Hague Opium Convention	Commits U.S. to pass drug control legislation
1914	Harrison Anti-Narcotic Act	Establishes physicians as gatekeepers of access to opiates and cocaine
1919	Webb v. United States Supreme Court decision	Threatens legal punishment for physicians medically maintaining addicts on opiates
1922	Narcotics Import and Export Act	Prohibits importation of processed morphine and cocaine into the U.S.

1924	Heroin Act	Prohibits importation of opium for use in manufacture of heroin
1937	Marihuana Tax Act	Prohibits sale and possession of cannabis
1942	Opium Poppy Control Act	Prohibits growth/harvesting of opium poppies without license
1951	Boggs amendment to the Harrison Act	Implemented mandatory minimums in sentencing of drug offenders
1956	Narcotic Control Act	Increases penalties and introduces first death penalty provision within drug control legislation

In 1966, Congress passed the Narcotic Addicts Rehabilitation Act (NARA), which provided treatment as an alternative to incarceration for narcotic addicts. This was followed by a further liberalization of drug laws in the 1970s, sparked primarily by concern with youthful drug experimentation and reports of heroin addiction among American soldiers in Vietnam. It was during the administration of President Richard Nixon that national drug policy shifted from an emphasis on law enforcement to one that placed a greater emphasis on prevention and treatment. This was followed in the 1980s by a backlash against what were perceived as "soft" approaches to the drug problem. This backlash was fueled by growing alarm about new patterns of cocaine addiction and drug-related violence. President Reagan re-allocated the national drug control budget, shifting two-thirds of the total budget into law enforcement with the remaining dollars devoted to prevention and treatment—exactly opposite the ratio established during the Nixon years.

Where earlier policy had focused resources on those drugs with greatest risks and social costs, e.g. heroin, Reagan's position of "zero tolerance" shifted the focus from treating addiction to discouraging casual drug use, particularly marijuana use. The representation of drug offenders among the state prison population jumped during the Reagan era from one in fifteen inmates to one in three inmates, with 85 percent of these offenders incarcerated on possession charges (Baum, 1996).

The explosive growth of prisons in the closing decades of the twentieth century was a product of increased incarceration of drug offenders. There are now more than 1.5 million drug-related arrests per year in the U.S. (up more than 1 million since 1980), and drug-offenders now make up more than 60% of the

federal prison population (Office of Applied Statistics, SAMHSA, 2000). The racial disparities reflected within these trends are glaring. While African Americans represent only 15% of illicit drug consumers, they constitute 60% of those incarcerated in state prisons on felony drug convictions (USDJ, 2000). While the rate of pre-natal exposure of infants to drugs is the same for Caucasian and African American women, the latter are ten times more likely to be reported to child welfare authorities for pre-natal drug exposure (Neuspeil, 1996).

Figure 7: Drug Control Policy/Legislative Milestones: 1960-Present

Year	Event	Significance
1963	President's Advisory Commission on Narcotics and Drug Abuse	Recommends exploring option of treatment for drug offenders as an alternative to incarceration
1965	Drug Abuse Control Amendments	Provides strict controls on amphetamines, barbiturates and LSD
1972	President's Commission on Marijuana and Drug Abuse	Recommends relaxation of marijuana laws; 12 states follow with decriminalization laws.
1970	Controlled Substances Act	Replaced all previous drug legislation; introduces drug scheduling
1984	Crime Control Act	Increased mandatory minimum penalties for drug possession/sale; property forfeiture provisions
1977	President Carter advocates federal decriminalization of marijuana	Drug-related controversies among White House staff led to abandonment of this initiative
1980	President Reagan introduces "zero tolerance" for drug use	Restigmatization, Demedicalization, & Recriminalization of alcohol & other drug problems

1986 1988	Anti-Drug Abuse Act	Acts focuses on discouraging causal drug use; 2/3rds of funds go for law enforcement; 1/3 for prevention and treatment

There were many influences that shaped the anti-drug campaigns detailed above, but one glaring theme is the association of particular drugs with specific minority groups. The West Coast anti-opium campaign of the 1870s linked opium to the Chinese during a period of intense racial and class conflict. The first anti-cocaine laws in the South linked cocaine with violence by blacks at a time there is little evidence of widespread cocaine use among African Americans. This history continued: the drive toward alcohol prohibition tapped anti-Catholic and anti-German sentiment, the anti-heroin campaign tapped growing fears about crime and violence by immigrant youth, the anti-cannabis campaign heavily targeted Mexican immigrants, and the anti-cocaine laws of the 1980s were targeted primarily against poor communities of color.

What led to the rebirth of treatment between 1940-1970?

Two advancements were required to lay the foundation for the rise of a national network of community-based addiction treatment programs in the 1970s and 1980s: 1) a fundamental change in public attitudes and policies, and 2) the development of credible and replicable treatment models.

A number of institutions pioneered new approaches to alcohol-related problems in the 1940s and 1950s. Their collective efforts have been christened the Modern Alcoholism Movement.

- Alcoholics Anonymous and its professional friends re-instilled optimism about the prospects of long-term recovery.
- The Research Council on Problems of Alcohol promised a new scientific approach to the prevention and management of alcohol problems.
- The Yale Center of Studies on Alcohol conducted alcoholism-related research, educated professionals, established a clinic model of outpatient treatment, and promoted occupational alcoholism programs.
- The National Committee for Education on Alcoholism, founded by Mrs. Marty Mann in 1944, waged an unrelenting public education campaign about alcoholism and encouraged local communities to establish detoxification and treatment facilities.

There were five "kinetic" ideas (developed by Dwight Anderson and Marty Mann) that were at the center of this Modern Alcoholism Movement's re-engineering of public opinion and legislative policy.

Figure 8: Anderson and Mann's Five "Kinetic" Ideas
1. Alcoholism is a disease. 2. The alcoholic, therefore, is a sick person. 3. The alcoholic can be helped. 4. The alcoholic is worth helping. 5. Alcoholism is our No. 4 public health problem, and our public responsibility. (Mann, 1944)

The modern alcoholism movement was actually many movements—each aimed at changing how particular institutions viewed alcoholism and the alcoholic. The targeted institutions were those of religion, law, business, medicine and the media. The success of the movement was indicated by the increased percentage of American citizens who viewed alcoholism as a sickness from 6% in 1947 to 66% in 1967, and the number of professional organizations making public pronouncements about alcoholism in the 1950s and 1960s (See Figure 9).

Figure 9: Key Policy Statements on Alcoholism (1950-1970)

Year	Organization	Position
1951	American Hospital Association (AHA)	Resolution on "Admission of Alcoholic Patients to the General Hospital" declares alcoholism a "serious health problem"
1952	American Medical Association (AMA)	Defines alcoholism
1956	AMA	Resolution calling on general hospital to admit the alcoholic as a "sick individual"
1957	AHA	Resolution urging local hospitals to develop programs for the treatment of alcoholism
1963	American Public Health Association	Resolution declaring alcoholism a treatable illness

1965	American Psychiatric Association	Publishes a statement recognizing alcoholism as a disease
1967	AMA	Resolution that alcoholism is a “complex disease that merits the serious concern of all members of the health professions”

The shift in public attitude and professional policy were crystallized in the work of the Cooperative Commission on the Study of Alcoholism whose 1967 report called for a comprehensive, national approach to the prevention and treatment of alcohol problems as well as investments in alcoholism-related professional training and research. The Commission report provided a blueprint for the modern system of alcoholism treatment.

The first state first state alcoholism commissions were organized in the 1940s, and several alcoholism treatment modalities emerged between 1940 and 1965, including:

- hospital-based detoxification and brief (5 day) treatment models via A.A. collaboration with hospitals in Akron, New York City, Cleveland, Philadelphia, Chicago,
- an outpatient clinic model pioneered in Connecticut and Georgia,
- a residential model (the “Minnesota Model of Chemical Dependency Treatment”) developed at Pioneer House, Hazelden and Willmar State Hospital, and
- a halfway house movement of the 1950s that championed the need for post-treatment recovery support services.

Federal support for alcoholism services grew in the 1960s through funding from the National Institute of Mental Health and the Office of Economic Opportunity. The decades-long campaign of the Modern Alcoholism Movement reached fruition with the passage of the Comprehensive Alcoholism Prevention and Treatment Act of 1970. This legislative milestone (often referred to as the “Hughes Act” for its champion, Senator Harold Hughes of Iowa), created the National Institute on Alcohol Abuse and Alcoholism (NIAAA) to lead a federal, state and local partnership to build, staff, operate and evaluate community-based alcoholism treatment programs across the United States. The number of alcoholism programs in the U.S. jumped from a few hundred in 1970 to more than 4,200 programs by 1980.

The growth of treatment programs for addiction to drugs other than alcohol

went through a similar process. First, there were reform campaigns that called for the movement of addicts from systems of control and punishment to systems of medical and psychological care. The earliest of these efforts resulted in the creation of two federal "narcotics farms" designed to rehabilitate narcotic addicts entering the federal prison system. These were opened in Lexington, Kentucky in 1935 and Fort Worth, Texas in 1938. Evaluations of these programs showing exceptionally high relapse rates for addicts returning to their communities created pressure to create local, community-based treatment alternatives. The work of the American Medical Association and the American Bar Association in the 1950s and 1960s played an important role in calling for the shift from a criminal justice to a public health approach to the problem of addiction. Growing drug use by white youth in the 1960s tipped the scales toward a major investment in addiction treatment.

To build a treatment system required replicable models of intervention and post-treatment recovery support. These came in four stages: the founding of Narcotics Anonymous in 1953, the birth of the therapeutic community via the founding of Synanon in 1958, the development of methadone maintenance by Drs. Dole, Nyswander and Kreek in the mid-1960s; and the emergence of a variety of drug-free outpatient therapies for youthful polydrug abuse during the late 1960s. These efforts came together in a 1971 in an executive order by President Richard Nixon that created the Special Action Office for Drug Abuse Prevention and the passage of the Drug Abuse Treatment Act of 1972. This law created a counterpart to NIAAA—the National Institute on Drug Abuse (NIDA)—to support the development of a national network of addiction treatment programs. The number of such programs in the U.S. increased from less than 100 in 1970 to more than 1800 in 1975. The era of modern treatment had begun, with about two thirds of the national drug control budget focused on demand reduction (prevention and treatment) through the Nixon, Ford and Carter administrations (Baum, 1996; Massing, 1999).

What were some of the most significant milestones in the modern history of addiction treatment?

The modern field of addiction treatment has experienced three phases in its development. The focus of the first stage (1970-1980) was on the development of federal, state and local organizational infrastructures through which treatment services could be planned, delivered and evaluated. This required:

- codification of treatment processes, e.g., the National Council on

Alcoholism's development of diagnostic criteria for alcoholism (1972),

- the development of national (NIAAA and NIDA) and state training systems to educate and professionalize addiction treatment personnel,
- the infusion of resources into research on addiction and treatment effectiveness,
- the emergence of addiction counseling as a "new profession" via the founding of the National Association of Alcoholism Counselors and Trainers (the precursor to NAADAC: The Association of Addiction Professionals) (1972) and state counselor associations,
- studies on core competencies of addiction counseling (the Littlejohn and Birch and Davis Reports of the mid-1970s) that formed the foundation of state counselor certification systems,
- the development of national accreditation and state licensure standards for treatment programs (early 1970s), and
- the highly controversial organizational integration of alcoholism and drug abuse treatment programs (1975-1985).

This first phase was resulted from hard-fought changes in public perception of alcoholism and the alcoholic created to a great extent by declarations of recovery from alcoholism by many prominent Americans, including First Lady Betty Ford. The National Council on Alcoholism played a significant role in this achievement via its Operation Understanding campaigns—press conferences held in 1976 and 1978 at which prominent people from diverse professions publicly announced their successful recovery from alcoholism.

The second phase in the development of modern treatment was characterized by an explosive growth of addiction treatment driven by the increase in inpatient hospital and for-profit residential treatment programs (and franchises). This initial trend was spurred by the decision of many insurance companies to begin offering alcoholism treatment benefits within their health policies. Rapidly rising costs of addiction treatment and exposure of ethical abuses related to aggressive marketing, inappropriate admissions and lengths of stay led to a rapid curtailment of these benefits and the emergence of an aggressive program of managed behavioral health care during the late 1980s. Between 1988 and 1993, a large number of these programs were closed, and others shifted their emphasis from inpatient to outpatient services. This period of explosive growth and backlash lasted roughly from 1981 to 1993. There was also an ideological backlash during this period that

challenged many of the foundational concepts of addiction treatment, e.g., the disease concept of alcoholism.

The modern field of addiction treatment moved into a stage of maturity as it entered the twenty-first century. This maturation is evident in the aging and beginning exit of its first and second generation leaders, the expansion of programs for special populations, near universal interest in bridging the gap between research and front-line clinical practices, and the movement of treatment services into other social systems, e.g., the child welfare system, the criminal justice system, and public health agencies (particularly those involved in HIV/AIDS-related services). There is also evidence of the field's philosophical maturation via the shift from ideological intolerance (single-modality programs believing their approach was the only way to treat all addiction) to a growing recognition that substance use disorders spring from multiple etiological pathways, unfold in diverse patterns and needs, respond to a variety of treatments, and resolve themselves through multiple pathways and styles of long-term recovery.

Some of the most important technical achievements during this evolution of modern treatment include research-validated screening/assessment instruments and diagnostic and placement criteria; early intervention programs (EAP, SAP, Family Intervention); replicable treatment models that span multiple and linked levels of care; effective outreach and engagement techniques (e.g., motivational interviewing); an expanded menu of psychopharmacological adjuncts; evidence-based, manualized therapies; age-, gender- and culturally-informed treatment; relapse prevention tools; and an expansion of post-treatment recovery support services (see Chapter 19 for a discussion of recovery tools). The most significant systems achievement during the modern era has been the resilience of the federal, state and local partnership that has shared responsibility for building, staffing, operating, monitoring and evaluating community-based addiction treatment programs.

As this book goes to press, there are two movements that promise, by their success or failure, to reshape the future of addiction treatment. The first is a treatment renewal movement that seeks to get the field of addiction treatment ethically re-centered, move addiction treatment providers back into deep relationships with the communities out of which they were born, and to re-link treatment to the larger and more enduring process of addiction recovery (White, 2002a). The second is a new recovery advocacy movement led by recovering people and their families that is trying to counter the restigmatization, demedicalization and recriminalization of alcohol and other drug problems. These grassroots organizations are putting a face and a voice on recovery, pushing pro-recovery policies, and working to expand treatment and recovery support services

within local communities (White, 2001b). The energy generated by these two movements makes it an exciting time to enter the world of addiction treatment.

So what does this history tell us about how to conduct one's life in this most unusual of professions?

The lessons from those who have gone before you are very simple ones. Respect the struggles of those who have delivered the field into your hands. Respect yourself and your limits. Respect the individuals and family members who seek your help. Respect (with a hopeful but healthy skepticism) the evolving addiction science. And respect the power of forces you cannot fully understand to be present in the counseling process. Above all, recognize that what addiction professionals have done for more than a century and a half is to create a setting and an opening in which the addicted can transform their identity and redefine every relationship in their lives, including their relationship with alcohol and other drugs. What we are professionally responsible for is creating a milieu of opportunity, choice and hope. What happens with that opportunity is up to the addict and his or her god. We can own neither the addiction nor the recovery, only the clarity of the presented choice, the best clinical technology we can muster, and our faith in the potential for human rebirth. The individuals, families and communities impacted by alcohol and other drugs need and deserve a new generation of addiction counselors who are willing to dedicate their lives to carrying forth the movements chronicled in this chapter. For those willing to follow that calling, I bequeath you a field whose rewards are matched only by its challenges (Adapted from White, 1998).

References

Baum, D. (1996). *Smoke and mirrors: The war on drugs and the politics of failure*. Boston: Little, Brown and Company.

Courtwright, D. (1982). *Dark paradise: Opiate addiction in America before 1940.* Cambridge, MA: Harvard University Press.

Courtwright, D. (1991). Drug legalization, the drug war, and drug treatment in historical perspective. *Journal of Policy History, 3,* 393-414.

Levine, H. (1978). The Discovery of Addiction: Changing Conceptions of Habitual Drunkenness in America. *Journal of Studies on Alcohol, 39*(2), 143-174.

Mann, M. (1944). Formation of a National Committee for Education on Alcoholism. *Quarterly Journal of Studies on Alcohol,* 5(2):354.

Massing, M. (1999). *The Fix*. New York: Simon & Schuster.
Musto, D. (1973). *The American Disease: Origins of Narcotic Controls.* New Haven: Yale University Press.
Musto, D. (1974). History of drug control. In P. Levin (Ed.), *Contemporary Problems of Drug Abuse*. Pp. 26-38, Acton, MA: Publishing Sciences Group, Inc.
Neuspeil, D. R. (1996). Racism and perinatal addiction. *Ethnicity and Disease, 6*, 47-55.
Rorabaugh, W. (1979). *The alcoholic republic: An American tradition.* Oxford: Oxford University Press.
Substance Abuse Treatment in Adult and Juvenile Correctional Facilities: Findings from the 1997 Survey of Correctional Facilities. (2000). Rockville, MD: Office of Applied Statistics, Substance Abuse and Mental Health Services Administration, Department of Human Services.
U.S. Department of Justice, Bureau of Justice Statistics. (2000). *Prisoners and Jail Inmates at Midyear 1999.* Washington DC: author.
White, W. (1998). *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. Bloomington, IL: Chestnut Health Systems.
White, W. (2001a). Pre-AA Alcoholic Mutual Aid Societies. *Alcoholism Treatment Quarterly, 19*(1), 1-21.
White, W. (2001b). The New Recovery Advocacy Movement: A Call to Service. *Counselor, 2*(6), 64-67.
White, W. (2002a). The Treatment Renewal Movement. *Counselor, 3*(1), 59-61.
White, W. (Ed). (2002b). The Addiction Disease Chronologies of William White, Ernest Kurtz, and Caroline Acker. Retrieved from www.bhrm.org
White, W. (In Press; Accepted 3-4-2002) Alcoholic Mutual Aid Societies. In Blocker, J. and Tyrell, I., Eds. *Alcohol and Temperance in Modern History*. Santa Barbara, CA: ABC-CLIO.

Further Reading

Inciardi, J. (1986). *The War on Drugs: Heroin, Cocaine, Crime and Public Policy.* Palo Alto, CA: Mayfield Publishing Company. (An excellent and highly readable account of modern drug trends and drug policies.)
Kurtz, E. (1979). *Not God: A History of Alcoholics Anonymous*. Center City, Mn: Hazelden. (The definitive history of Alcoholics Anonymous.)
Morgan, H. (1981). *Drugs in America: A Social History 1800-1980*. Syracuse, NY: Syracuse University Press. (Perhaps the best single history of illicit

drug use in America.)
Sinclair, A. (1962). *Era of Excess: A Social History of the Prohibition Movement.* New York: Harper & Row Publishers. (*The* book to read if you are interested in the social history of prohibition.)

Discussion questions

1) What technological developments influenced the history of addiction in America?
What future technological breakthroughs could influence the history of addiction in the twenty-first century?

2) As alcohol and other drug problems grew in the nineteenth century, there was a struggle to define whether these problems were the province of religion, law, or medicine. What institutions are competing for ownership of these problems today, and what is your perception of how these institutional interests affect social policy?

3) Evaluate the health or vulnerability of the modern field of addiction treatment using the six factors discussed in this chapter.

4) Given the demise of all of A.A.'s predecessors, what factors contributed to A.A.'s growth and endurance?

5) What is your perception of the current role of race, class and generational conflict in recent anti-drug campaigns, the application of drug laws via arrest and sentencing, and access to treatment?

6) How have public opinions changed between 1944 and the present regarding Anderson and Mann's five "kinetic" ideas?

7) Cultural responses to addiction treatment modalities often have little to do with scientific studies of their relative effectiveness. There was great popular support for therapeutic communities long before their effectiveness was evaluated, and great public and professional criticism of methadone maintenance long after its effectiveness had been overwhelmingly documented. How do you account for such cultural/professional and scientific disparities?

8) This chapter has reviewed the rise, fall and rebirth of addiction treatment and recovery mutual aid societies in America. What are your predictions about the

future of treatment and mutual aid movements? What are the most important factors that you think will shape this future?

9) The history of addiction treatment is marked by cycles of segregation (organization of a specialized field of addiction treatment) and integration (absorption of alcoholics and addicts into other systems of care or control). The abuses within or inadequacies of the latter generally lead to a process of re-specialization. What dangers, if any, do you think exist in the current integration of addiction treatment into broader conceptual (behavioral health) and service (merger of mental health and addiction treatment units) umbrellas?

10) Grassroots recovery advocacy organizations are again trying to counter the restigmatization, demedicalization and recriminalization of addiction in America. What effects do you think such organizations will exert on the field of addiction treatment?

Multiple Choice Questions

___1. Most people addicted to opiates in the 19th century were:
a. middle-aged white women
b. aging Chinese men
c. young African American men
d. young Italian immigrants

___2. What technological achievement contributed to the rise of narcotic addiction in the 19th century?
a. introduction of the hypodermic syringe
b. packaging of morphine and cocaine together
c. synthesis of demerol
d. introduction of a morphine inhaler

___3. What innovation contributed to the rise of nicotine addiction in the 19th century?
a. pipe
b. cigarette
c. wooden match
d. filtered cigarette

___4. The pioneer physician who rightly deserves the title of the "Father of Addiction Medicine" and the "Father of the Addiction Disease Concept" is:
a. David Smith
b. E.M. Jellinek
c. Benjamin Rush
d. William Silkworth

___5. The person responsible for coining the term, alcoholism, was:
a. Dr. Benjamin Rush
b. Dr. Eli Todd
c. Dr. Magnus Huss
d. Dr. E.M. Jellinek

___6. The preferred 19th century term to refer to the condition of chronic drunkenness was:
a. inebriety
b. dipsomania
c. alcoholism
d. methomania

___7. The first medically-oriented addiction treatment institution in the

United States opened in:
a. 1794
b. 1864
c. 1924
d. 1964

___8. Which of the following institutions were noted for prolonged periods of residential care and physical methods of treatment?
a. inebriate homes
d. inebriate penal colonies
c. inebriate asylums
d. urban missions

___9. A 1906 expose of the patent medicine addiction cures revealed that most of the cures for morphine addiction contained:
a. morphine
b. cocaine
c. high proof alcohol
d. cannabis

___10. Which of the following branches of 19th century treatment was organized to make a profit for its owners/stockholders?
a. inebriate homes
b. addiction cure institutes
c. inebriate asylums
d. rural inebriate colonies

___11. Which of the following has not been used in the treatment of alcoholism?
a. LSD
b. amphetamines
c. PCP
d. barbiturates

___12. An outpatient clinic model of alcoholism psychotherapy provided by lay therapists (recovered alcoholics) was pioneered at:
a. Hazelden
b. the Emmanuel Church of Boston
c. Towns Hospital

d. Bellevue Hospital

___13. Which of the following recovery mutual aid societies was not birthed inside a treatment institution?
a. Godwin Association
b. Keeley Leagues
c. Ollapod Club
d. Washingtonian Temperance Society

___14. Which of the following is not a secular alternative to Alcoholics Anonymous?
a. Women for Sobriety
b. Rational Recovery
c. Secular Organization for Sobriety
d. Alcoholics Victorious

___15. The first major alternative to Alcoholics Anonymous was:
a. Women for Sobriety
b. Rational Recovery
c. Secular Organization for Sobriety
d. Moderation Management

___16. Which acronym represents the first recovery mutual aid society developed specifically for alcoholic women?
a. SOS
b. WFS
c. CA
d. WAA

___17. National alcohol prohibition in America lasted from 1919 to ____.
a. 1923
b. 1933
c. 1943
d. 1953

___18. The first anti-narcotics ordinance in the United States occurred in what city?
a. San Francisco

b. Chicago
c. Philadelphia
d. Jamestown

___19. The Pure Food and Drug Act of 1906:
a. required a physician prescription to obtain opium or morphine
b. required labeling of products containing alcohol, opium and morphine
c. prohibited the growing of opium poppies in the U.S.
d. prohibited the manufacture of heroin

___20. The law that will mark the onset of the criminalization of the status of drug addiction in the United States (in effect if not intent) was the:
a. Pure Food and Drug Act
b. Marihuana Tax Act
c. Harrison Anti-Narcotic Act
d. the France Bill

___21. Marijuana was first nationally prohibited under what law?
a. The 1906 Pure Food and Drug Act
b. The 1914 Harrison Anti-Narcotic Act
c. The 1937 Marihuana Tax Act
d. The Controlled Substances Act of 1970

___22. What five-year period marked the most explosive growth of incarceration of drug offenders in American history?
a. 1900-1905
b. 1940-1945
c. 1960-1965
d. 1985-1990

___23. The first anti-cocaine laws were associated with what group of people?
a. Chinese immigrants
b. African Americans
c. Mexican immigrants
d. Eastern European immigrants

___24. The five “kinetic” ideas around which the Modern Alcoholism Movement was organized were developed by:

a. Bill W. and Dr. Bob
b. Dr. E.M. Jellinek
c. Senator Harold Hughes
d. Dwight Anderson and Marty Mann

___25. Which of the following is not one of the “kinetic ideas” of the modern alcoholism movement launched in the 1940s:
a. Alcoholism is hereditary
b. Alcoholism is a disease
c. The alcoholic is a sick person
d. The alcoholic can be helped

___26. The decade most associated with the rise of alcoholic halfway houses was the:
a. 1950s
b. 1960s
c. 1970s
d. 1980s

___27. The absence of treatment for narcotic addiction changed in the 1930s with:
a. the introduction of methadone maintenance
b. the opening to two federal narcotic “farms”
c. passage of civil commitment laws
d. the introduction of narcotic antagonists

___28. Most addiction counselor certification systems were organized in the:
a. 1960s
b. 1970s
c. 1980s
d. 1990s

___29. The most dramatic decline in the number of private and hospital-based addiction treatment programs occurred between:
a. 1969-1974
b. 1975-1980
c. 1981-1987
d. 1988-1993

___30. The financial backlash against addiction treatment in the late 1980s

and early 1990s was in reaction to:
a. an unexpected economic depression
b. financial exploitation of clients/families by addiction treatment providers
c. the perception that addiction counselors were being overpaid
d. a dramatic increase in public dollars allocated to addiction treatment

Glossary

American Temperance Movement: A social movement arising in the early nineteenth century that, following a brief call for moderation of alcohol consumption, generated mandatory temperance education, drinking age laws and eventually the drive to legally prohibit the sale of alcohol.

Inebriety/Inebriate: Inebriety was the term for what today would be called addiction; the person suffering from addiction was known as an inebriate.

Inebriate Asylums: Medically-directed institutions for the long-term care of the inebriate.

Inebriate Homes: Residential homes for the care of inebriates that portrayed recovery as a sobriety decision (pledge signing), a process of moral reformation, and a process of mutual surveillance and support.

Habitues: A nineteenth century term used most frequently to depict those who had become dependent upon opium or morphine, later expanded to encompass those addicted to any drug.

Harrison Act: The 1914 act that set the stage for the criminalization of the status of narcotic addiction in the United States.

Keeley Institutes: The largest chain of for-profit addiction cure institutes that flourished in the late nineteenth century.

Kinetic Ideas: Ideas and phrases thought to have power in galvanizing public opinion, e.g., “alcoholism is a disease.”

Lay Therapists: Recovered alcoholics trained to serve as lay psychotherapists within the Emmanuel Clinic in Boston and later used to depict recovered counselors who lacked formal training in medicine, psychology or social work.

Modern Alcoholism Movement: Term applied to the post-Repeal efforts of multiple organizations to change American perceptions of alcoholism and the alcoholic.

NARA: Narcotic Addict Rehabilitation Act that expanded access to treatment for narcotic addiction in the 1960s.

Narcotics Farms: Term applied to the federal prisons in Lexington, Ky and Forth Worth, TX that were designated for the treatment/containment of narcotic addicts within the federal prison system.

Volstead Act: The 1919 enforcement arm of federal prohibition of the sale of alcohol.

Webb v. United States: The 1919 Supreme Court decision that prohibited physicians from maintaining addicts on their “usual and customary dose”—the practical implication was the transfer of narcotic addicts from the medical community to the criminal justice community.