Federalizing Medical Campaigns against Alcoholism and Drug Abuse

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Context: The formation of the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the Special Action Office for Drug Abuse Prevention (SAODAP) in the early 1970s dramatically expanded scientific and medical efforts to control alcoholism and drug abuse in the United States.

Methods: Drawing on a variety of primary, secondary, and archival sources, this article describes the creation and early years of these agencies.

Findings: I show that while the agencies appeared at roughly the same time, their creation involved separate sets of issues and actors. In addition, I show that SAODAP received more money and resources, even though advocates for alcoholics mobilized a stronger lobbying campaign.

Conclusions: Two factors explain this discrepancy in money and resources: (1) alcoholism was framed as a public health problem, whereas drug abuse was drawn into broader debates about crime and social decline; and (2) alcohol programs relied on congressional support, whereas drug programs found champions at high levels of the Nixon administration. These political and cultural factors help explain why current programs for illegal drugs receive more federal support, despite alcohol's greater public health burden.

Keywords: alcoholism, drug abuse, substance abuse, National Institute on Alcohol Abuse and Alcoholism, National Institute on Drug Abuse, Special Action Office for Drug Abuse Prevention, policy history.

THE PROPOSED AND NARROWLY AVERTED REORGANIZATION OF the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA) has drawn attention to the national substance abuse research enterprise.

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Although policymakers rejected similar proposals in 1973 and 1987, citing the need to maintain the visibility associated with independent institutes (Gardner 1973; Lewin and Associates 1988), this time they placed a greater emphasis on achieving “synergies” across the alcohol and drug fields (NAS 2003; SMRB 2010). After launching a two-year, trans-NIH review of substance abuse research portfolios, the director of NIH abruptly terminated the reorganization for reasons that remain unclear. This lengthy and tumultuous process has raised a number of issues. Should the new institute’s portfolio be limited to dependence, or should it cover other adverse consequences of alcohol and drug use, such as cirrhosis, fetal alcohol spectrum disorders, and HIV/AIDS? Is it wise to encourage closer collaborations between communities of researchers that have historically maintained separate identities? Would the reorganization result in more or less research funding overall? Underlying all these questions, and exacerbating tensions between alcohol and drug researchers, is the relative size of the two institutes. For many decades, because NIDA is roughly twice as large as NIAAA, alcohol researchers have worried that their programs will be dwarfed in a reorganized institute. Alcohol researchers are also quick to point out that the public health burden of alcohol far exceeds the public health burden of illicit drugs, NIDA’s primary focus.

This article uses history to reach a deeper understanding of the present. It considers the creation of NIAAA and the Special Action Office for Drug Abuse Prevention (SAODAP), NIDA’s short-lived but influential predecessor (figure 1). The establishment of NIAAA and SAODAP in the early 1970s marked a turning point in medical and scientific efforts to control substance abuse. Between 1935 and 1970, research was conducted on a small scale; the Public Health Service treated a handful of drug addicts at facilities in Lexington, Kentucky, and Fort Worth, Texas; and Alcoholics Anonymous (AA) was the dominant treatment modality for alcoholics (Campbell 2007; Roizen 1991). Nevertheless, most alcoholics and drug addicts were sequestered in mental hospitals and jails, if they received any attention at all (White 1998, 178–261). NIAAA, SAODAP, and NIDA were initially created to address this dearth in treatment options. During the 1970s, these agencies spurred the growth of a substance abuse treatment industry, laid the groundwork for today’s research enterprise, and institutionalized funding disparities between alcohol and drug programs. Understanding the events surrounding the creation of NIAAA and SAODAP therefore sheds light on

FIGURE 1. Federal alcohol and drug agencies, 1966–1974.

the reasons why medical and scientific programs for illicit drugs have outpaced comparable programs for alcohol.

The first section of this article examines those advocates who attacked punitive approaches to alcohol and drug problems in the 1940s, 1950s, and 1960s, as well as the expansion of alcohol and drug programs at the National Institute of Mental Health (NIMH). The next section considers the passage of authorization legislation for federal alcohol and drug agencies, along with the justifications used to substantiate them. Finally, the third section describes issues surrounding the initial implementation of NIAAA and SAODAP. Overall, the article demonstrates that the early 1970s were a golden age for drug experts, whereas alcohol experts struggled to launch NIAAA and keep it afloat. There are three reasons why this result, in retrospect, is somewhat surprising. First, at the time alcohol was widely considered a bigger problem than illegal drugs. Even though the generation of prevalence figures was notoriously controversial (Josephson and Carroll 1974; Weiner 1981, 177–97), the difference between them was substantial. According to official estimates, there were roughly 9 million alcoholics, compared with 100,000 to 500,000 heroin addicts (NIMH 1969; SCDA 1973; US Senate 1970a, 124). Second, alcoholism was less stigmatized than drug addiction. Self-proclaimed alcoholics regularly spoke about their struggles, and they received sympathetic coverage in the popular media. Drug addicts, in contrast, were typically portrayed as criminals and rarely spoke publicly on their own behalf. Third, and perhaps most important, alcoholics had a stronger special-interest group, whereas advocacy for drug addicts came largely from professional circles, which fought a rear-guard action against proponents of law enforcement. Conversely, the advocates for alcoholics had political connections and combined professional and grassroots support into a loosely coordinated but powerful movement.

This article argues that SAODAP fared better than NIAAA for two reasons. First, alcohol and drug problems were framed in different ways: alcohol was largely seen as a public health problem, while drug problems resonated with broader concerns about crime and cultural decline. Second, advocates for alcoholics and drug addicts found political allies in different branches of the federal government: the former relied on Senator Harold Hughes (D-IA), while the latter had strong supporters in the Nixon administration. These two factors conspired against alcohol programs. President Richard M. Nixon wanted to decrease the size of

the federal government, so he obstructed the creation and implementation of NIAAA. But he made an exception for SAODAP because he was eager to appeal to “silent majority” voters; he was worried about addicted soldiers and what they might do when they returned home; and he thought that drug treatment would reduce urban crime in time for the election of 1972. As a result, alcohol experts had to rely on congressional oversight to compel the administration to act, while drug experts quickly received the authority and resources they needed. Over the long term, these events institutionalized a disparity in funding for federal alcohol and drug programs, an issue considered in the conclusion of this article.

Advocacy for Alcoholics and Drug Addicts

The creation of federal alcohol and drug agencies in the early 1970s was made possible by advocacy efforts that had played out over the preceding three decades. Both movements involved professionals who pursued legal and medical reforms. Yet the alcoholism movement was stronger because it also included a grassroots constituency and a patient advocacy organization with close ties to Alcoholics Anonymous.

The Rise of the “Alcoholism Movement”

After Prohibition was repealed, a movement was formed to address drinking problems in American society. Unlike the temperance movement that preceded it, this social movement purposely distanced itself from politically charged questions about the status of alcohol and focused instead on people who were unable to abide by social drinking norms (Anderson 1942). Guided by the notion that alcoholism was a disease, though much less clear about what this meant, the so-called alcoholism movement became increasingly institutionalized after 1935. Among the more influential organizations that advocated on behalf of alcoholics were Alcoholics Anonymous (AA, a mutual aid group), the National Council on Alcoholism (NCA, a patient advocacy organization), the Center of Alcohol Studies (CAS, an academic center), the North American Association of Alcohol Providers (NAAAP, an association of practitioners), the American Medical Association’s Subcommittee on Alcoholism, and the Cooperative Commission on the Study of Alcoholism (CCSA,

a blue-ribbon commission). CAS and CCSA advanced a broader view of alcohol problems than the alcoholism-centric position espoused by AA and NCA. But the movement as a whole promoted the idea that alcoholism was a disease, and it attacked punitive responses to alcohol problems. By the end of the 1960s, the alcoholism movement convinced medical societies to denounce discrimination against alcoholics in hospitals, decriminalized public drunkenness, and expanded NIMH's alcohol programs.

AA changed American views about alcoholism from the bottom up. Although the fellowship was founded in 1935, it took a while to find its philosophical bearings, and it was divided into three factions when its Twelve-Step program was outlined in the Big Book in 1940. From the beginning, AA's primary goal has been to provide an environment in which alcoholics can help one another remain abstinent. AA's culture strictly prohibits political lobbying and discourages public relations campaigns. But it welcomes publicity. An honorary dinner held by the Rockefeller Foundation in 1940 and an article in the *Saturday Evening Post* (Alexander 1941) in 1941 introduced AA to the nation. Upon learning about the group's sympathetic approach, people from all over the country began seeking help for themselves or loved ones (Kurtz 1979, 83–134). During the 1940s, AA's organic growth was fueled by advocates from NCA, positive coverage in the news media (e.g., DuBois 1945), and movies that portrayed alcoholics as suffering from a disease, such as *The Lost Weekend* (1945). According to its published estimates, AA's membership surged from 1,400 in 1940, to 15,000 in 1945, and to 100,000 in 1950. By 1970, the group claimed more than 300,000 members, including wealthy alcoholics with political connections, like Brinkley Smithers and Thomas Pike (Johnson 1973, 278).

Even though NCA and AA were separate organizations with distinctive agendas, the boundary between them was blurry. CAS initially sponsored the National Committee for Education on Alcoholism in 1944, which changed its name to the National Council on Alcoholism in 1954. NCA was directed by Marty Mann, the first woman to join AA and a close friend of Bill Wilson, AA's cofounder and spiritual leader. Mann gave speeches throughout the country, imploring physicians and the public to consider alcoholism a disease. She also engaged popular media outlets. This communication strategy spurred the growth of local NCA branches, which distributed information and provided diagnostic services. In her 1950 *Primer on Alcoholism*, Mann described a variety

of treatment methods, noting the distinctions between AA and NCA. Nonetheless, she remained an outspoken proponent of mutual aid. Her discussion of AA was much more flattering than her discussions of medical and psychiatric treatments, and her efforts to underscore the distinctions between AA and NCA suggest that many people believed they were working from the same playbook (Mann 1950). In her speeches and her book, Mann insisted that alcoholics were allergic to alcohol, and she maintained that the disease theory of alcoholism was a scientifically proven fact. Such claims created tensions with CAS, which stressed the psychosocial aspects of alcoholism and considered the disease theory a work in progress. Although NCA experienced financial troubles after it split with CAS in 1949, this changed in 1955, when the Smithers Foundation became the group's benefactor (Smithers Foundation 1992, 9). NCA then became the principal advocacy group for alcoholics, and it remained a strong proponent of the AA approach (Johnson 1973, 270–75, 285–95, 310–13, 323).

In addition to promoting recovery through mutual aid, the alcoholism movement used two initiatives to professionalize alcoholism treatment, with CAS centrally involved in both. First, in 1944, CAS created diagnostic clinics in New Haven and Hartford, which were transferred to the state of Connecticut the following year. Shortly thereafter, New Hampshire established similar clinics, and by 1949 twelve states and the District of Columbia had done the same. That summer, leaders of state alcoholism programs met at CAS and formed the National Conference of State Agencies on Alcohol Problems. This organization, which came to be called the North American Association of Alcoholism Providers (NAAAP), held conferences for service providers and sponsored publicity campaigns (Johnson 1973, 276–80, 308–9, 353–55). Thanks to a gift from the Smithers Foundation, NAAAP established an office in Washington, DC, in 1962 and began to lobby federal officials (Smithers Foundation 1992, 11). Second, professional advocates for alcoholics targeted the American Medical Association (AMA). Marvin Block (a physician in Buffalo, NY) established an alcoholism committee in the Erie County Medical Society in 1947. With the help of Seldon Bacon from CAS, Block drew up plans for an alcoholism subcommittee in the AMA. The AMA's board of trustees rejected the proposition in 1950 but eventually created an alcoholism subcommittee under its Committee on Mental Health in 1954. At the subcommittee's insistence, the AMA's House of Delegates passed a resolution in 1956 condemning

discrimination against alcoholics in hospitals. The American Hospital Association followed suit in 1957 (Johnson 1973, 314–21; Plaut 1967, 191–93). These declarations represented major policy shifts, though their actual impact was fairly limited.

While other components of the alcoholism movement consolidated professional support, Peter Hutt, a Washington-based lawyer, worked with the American Civil Liberties Union (ACLU) to test the constitutionality of public intoxication laws. Starting in 1963, Hutt defended homeless alcoholics who were repeatedly arrested for being drunk in public, and three of these cases—*Driver v. Hinnant*, *Easter v. District of Columbia*, and *Powell v. Texas*—entered the appeals process. Prosecutors maintained that the defendants had willfully violated the law, but Hutt argued that the disease of alcoholism colluded with dire economic straits to force the defendants to drink excessively in public. Given these circumstances, Hutt contended that imprisoning them for public drunkenness was cruel and unusual punishment. Although he won the *Driver* and *Easter* cases in federal appeals courts, NCA submitted an equivocal amicus curiae in the *Powell* case, and Hutt's Eighth Amendment argument was narrowly defeated in the Supreme Court. (NCA objected to the lawsuit because it reinforced stereotypes about skid row alcoholics.) Nevertheless, the campaign raised the visibility of the alcoholism movement, and Congress quickly passed a law that partially decriminalized public drunkenness in Washington, DC (Johnson 1973, 359–63; interview with Peter Hutt, August 22, 2011).

As the preceding suggests, the alcoholism movement involved advocacy on multiple fronts. AA worked from the ground up, saving one alcoholic at a time; NCA campaigned to change public opinions about alcoholics; NAAAP and the AMA's alcoholism subcommittee consolidated professional support for alcoholism treatment; and the ACLU challenged the constitutionality of public drunkenness laws.

The Cooperative Commission on the Study of Alcoholism (CCSA) translated these disparate initiatives into specific policy recommendations. The commission was formed in 1955 and staffed by professionals from NAAAP and CAS who were uncomfortable with the disease-centric orientation of AA and NCA (e.g., David Archibald, Thomas Plaut, E.M. Jellinek, Seldon Bacon, and Robert Straus). After a slow start, the commission received a \$1.1 million grant from NIMH in 1960 to conduct a study of the country's alcohol problems (Johnson 1973, 336–49). Published in 1967, its final report (Plaut 1967) outlined a proposal for a

national alcohol program, and many of its recommendations were eventually incorporated into NIAAA's service programs during the 1970s.

Unlike NCA and AA, CCSA did not focus on alcoholism because it worried that the term would lead to oversimplification and stereotyping. Instead, CCSA organized its report around "problem drinking," which it defined as the "repetitive use of beverage alcohol causing physical, psychological, or social harm to the drinker or to others" (Plaut 1967, 37–38, 41). Problem drinking appeared in a variety of forms and stemmed from many indeterminate causes. Drinking problems included disagreements about how to handle disruptive drinkers, drinking and driving, and destructive drinking behaviors (Plaut 1967, 7–8). Problem drinkers, according to CCSA, occupied every rung of the socioeconomic ladder: the "young executive who becomes a hazard on the highway as he drives home after parties," the "factory worker whose episodes of excessive drinking cause his family much suffering," and the "homeless Skid Row man" (Plaut 1967, 17). The commission argued that problem drinkers' physiological peculiarities made alcohol particularly stress relieving. But their personalities made it hard for them to deal with depression and frustration, and they encountered ambiguous norms about how, and how much, to drink (Plaut 1967, 49). By approaching alcohol problems in this manner, therefore, the commission identified a public health problem that encompassed a wide range of pathological behaviors and was caused by a variety of factors.

CCSA addressed the complexity of problem drinking by proposing a range of policies. Its goal was to coordinate a system that was hamstrung by inadequate resources and conflicting agendas. According to the commission, ambivalent drinking norms, along with significant differences among problem drinkers, stymied treatment and rehabilitation programs (Plaut 1967, 11, 33–34, 53, 80). Most programs attended to particular types of alcohol problems, and their failure to "view them in a broad context" led to "narrow, piecemeal, [and] ineffective remedies" (Plaut 1967, 12, 54). Under this arrangement, alcoholism clinics, halfway houses, and other facilities worked in isolation, and problem drinkers had trouble accessing health insurance, general hospitals, and welfare agencies. CCSA's primary recommendation was to establish, expand, and integrate alcohol services. Problem drinkers needed to be treated compassionately, and alcohol programs needed to embrace a variety of treatment approaches, in settings that were connected to transitional facilities and referral services (Plaut 1967, 86–89). In order to

achieve these public health goals, the commission urged strong leadership at the federal level.

By the time CCSA published its report, NIMH was already taking steps to elevate its alcohol problems. In 1964, NIMH operated a single section for alcohol and drugs. In 1966 it created the National Center for the Prevention and Control of Alcoholism (NCPCA), and Thomas Plaut (the author of the CCSA report) soon became the center's assistant chief (NIMH n.d.). NCPCA had a single professional staff position in 1965, rising to eight in 1967 and twenty-two in 1969 (NIMH 1966–1969). In 1967, Congress authorized funding for alcoholism treatment services in both the NIMH's Community Mental Health Centers (P.L. 90-574) and the Office of Economic Opportunity's Community Action Programs (P.L. 90-222). President Lyndon B. Johnson praised these initiatives and called on Congress for more funding (Johnson 1968). By 1970, NCPCA was handing out roughly \$3 million in service grants, and \$5 million for alcoholism research (NIMH 1967). Spurred by the alcoholism movement, alcohol experts had gained a foothold in NIMH.

Advocating for Drug Addicts

Sustained advocacy for drug addicts appeared about a decade after the emergence of the alcoholism movement. Lacking grassroots support from mutual aid and patient advocacy groups, advocacy for drug addicts consisted primarily of ad hoc groups of scientists, physicians, and lawyers who sought to reform drug control laws and rehabilitate drug addicts outside the criminal justice system. These recommendations initially fell on deaf ears, but in 1966, they convinced the federal government to launch a civil commitment program. This expanded NIMH's drug program and eased the transition to community-based drug treatment approaches that appeared in the early 1970s.

National drug control laws can be traced to the Harrison Act of 1914, which prohibited the distribution of narcotics without a prescription, and a pair of Supreme Court cases in 1919, which made it illegal for physicians to dispense maintenance doses for narcotics addicts. This marked the beginning of an era of strict enforcement, emblemized by Harry Anslinger's reign as the director of the Bureau of Narcotics, which was established in 1930 (Musto 1999, 121–50). Many physicians resented this infringement on their medical autonomy, however, and

Alfred Lindesmith's sociological studies provided additional support for medical maintenance by recommending the British model, which allowed physicians to prescribe opiates to addicts and was credited with curtailing addiction and drug trafficking in that country (Lindesmith 1947, 204–10). (The British system was put into place in 1920, and British medical professionals maintained control over this aspect of drug policy in the decades thereafter; see Mold 2008.) Nevertheless, federal policies moved in the opposite direction when the Boggs Act of 1951 established minimum mandatory sentences for drug possession. In 1953, the Richmond County Medical Society in New York responded by passing a resolution in favor of medical maintenance (Berger 1956). The Medical Society of the State of New York passed the resolution the following year and referred it to the AMA. Proponents argued that the “supply of narcotics drugs simply has not been shut off during the forty years in which the Harrison Act has been on the statute books,” and they asserted that drug addicts committed crimes only because the drug control laws had created black markets (Howe 1955, 344).

The passage of the New York resolution prompted the AMA and the American Bar Association (ABA) to establish a joint committee to study drug control laws (Carroll 2004; King 1974, 161–74). As Rufus King, a member of the joint committee, described it, the project was immediately beset by internal divisions within the AMA, as well as disagreements between the AMA and the ABA over which one would provide financial support. At the end of 1956, the Russell Sage Foundation offered to fund the study, and after a series of delays, the joint committee's interim report was completed in 1958. Very few copies were printed, and the ABA and AMA quickly endorsed the committee's recommendations, the most sensitive of which was the creation of an experimental outpatient clinic to study the treatment of drug addicts in noninstitutionalized settings. This proposition deeply disturbed Anslinger and his allies in Congress. In an effort to quash the interim report, Anslinger formed his own advisory committee (a group that never met together in the same room); he repeatedly refused requests to meet with members of the ABA/AMA Committee; and he published a disjointed but widely circulated rebuttal under the auspices of the Treasury Department (Advisory Committee 1959). Meanwhile, the AMA/ABA Committee's final report did not appear until 1961, owing to difficulties securing a publisher. With an introduction by Alfred Lindesmith, the final report emphatically disfavored the legalization

of drugs. Nevertheless, it noted that physicians and lawyers objected to policies that emphasized “repression and prohibition to the exclusion of other possible methods.” According to the report, these policies were not sufficient in their own right, and strict sentencing requirements were counterproductive. In place of mandatory minimum sentences for drug possession, the committee recommended further research on outpatient treatment services (Joint ABA/AMA Committee 1961, 161–64).

While the joint committee was preparing its report, federal drug control policies became increasingly stringent. In 1955, Senator Price Daniel (D-TX) introduced legislation to strengthen the Boggs Act, and Public Health Service (PHS) officials were called to testify on the matter. These officials struck a middle ground, criticizing medical maintenance while stressing the importance of medical treatment for drug addicts. G. Hasley Hunt, for example, noted that the New York Medical Society resolution was thoughtful but misguided. According to Hunt, the “causes of addiction are multiple and complex,” and eliminating black markets would not solve the problem. Hunt thought that treatment should be the first priority for addicts without criminal backgrounds, but his experience in the field raised “serious doubts” about medical maintenance (US Senate 1955, 1463–64). Three years later, in 1958, the PHS organized a symposium on drug addiction, at which federal scientists reinforced this middle-ground position. For example, Lawrence Kolb, who previously ran the PHS’s Lexington Narcotics Hospital, chastised law enforcement officials for assuming that narcotics “cause deterioration and crime,” and he drew an unfavorable comparison between the Daniel Act and the Salem witch trials (US DHEW 1958, 97). Nevertheless, both he and other PHS officials insisted that the “maintenance of drug addiction is not treatment” (US DHEW 1958, 76).

Congress ultimately passed the Daniel Act, but Anslinger’s influence was then on the wane, and his retirement in 1962 set the stage for the liberalization of federal drug control laws. That same year, the Supreme Court ruled in *Robinson v. California* that in and of itself, drug addiction was not a crime (McMorris 1965). The following year, a presidential advisory committee published a report that favored a less punitive approach, including reduced sentences for simple possession (Musto and Korsmeyer 2002, 7–12; PACNDA 1963). Buoyed by the increasing tolerance of drug use during the countercultural revolution, this position gained momentum during the Johnson administration.

In particular, the federal civil commitment program, established by the Narcotic Addict Rehabilitation Act of 1966, responded to the commission's recommendation that drug addicts be allowed to enter treatment in lieu of prosecution for minor drug offenses. Modeled on programs that began in California and New York in the early 1960s and were then serving more than two thousand people (Kramer, Bass, and Berecochea 1968; US Senate 1966, 52–55), the federal program was jointly administered by the Justice Department and NIMH, and it decentralized and expanded the approach used at the Lexington Narcotics Hospital. Addicts remained in custody while they traveled to Lexington (or a similar facility in Fort Worth, Texas) for assessment. Those deemed suitable were then treated at these facilities or transported to other inpatient facilities throughout the country. Upon their release, addicts were supposed to participate in community-based aftercare programs. By 1968, NIMH was operating eleven field offices, which administered contracts with inpatient and aftercare providers (Yolles 1968). Civil commitment was expensive: between 1967 and 1971, it cost \$81 million to treat roughly four thousand patients. The program also encountered administrative problems, as the medical and legal aspects were poorly integrated, eligibility requirements were unclear, contractors were hard to find, and judges used the program to unload recidivists. Only 38 percent of those who tried to access NIMH's portion of the program were processed into aftercare facilities, and administrative hurdles made civil commitment less popular than anticipated (Besteman 1978; Lindblad 1988). Nevertheless, the program expanded NIMH's drug abuse efforts and brought new treatment providers into the field. This smoothed the transition between the inpatient approach used at Lexington and the outpatient approach that would be embraced by SAODAP.

The civil commitment program coincided with the expansion of NIMH's drug research. In 1966, NIMH created the National Center for Studies of Narcotics and Drug Abuse, which in 1968 became the Division of Narcotic Addiction and Drug Abuse. Thanks to the civil commitment program, professional staffing levels increased from six in 1967 to 124 in 1969. NIMH spent roughly \$1 million on drug research in 1966, \$1.7 million in 1967, and \$4 million in 1970 (NIMH 1969, 1971). By the end of the 1960s, drug experts had solidified their position in the federal bureaucracy. Although professionals played an important role in making this happen, they did so through a series of disconnected policy briefs (not by mobilizing a strong social movement), their efforts

were initially met with staunch opposition, and their eventual success was made possible by broader cultural and political developments (Musto 1999, 245–48).

Pathways to Authorization

By the end of the 1960s, advocates catalyzed NIMH's expansion of alcohol and drug programs. The election of Senator Harold Hughes and President Richard Nixon in 1968 gave advocates the political allies they needed to consolidate and extend their bureaucratic victories. In the following analysis of the passage of authorization legislation for NIAAA and SAODAP, I contend that legislation for alcohol and drug agencies emerged from different branches of the federal government. I maintain that NIAAA was justified in terms of public health needs and that SAODAP was tied to broader concerns about crime and cultural decline.

Federal Leadership to Reduce the Burden of Alcoholism

The alcoholism movement gained an invaluable political ally when Harold Hughes was elected to the Senate. He drew attention to the problem of alcoholism, and over the objections of the Nixon administration, he steered authorization legislation for NIAAA through Congress. Throughout, Hughes and his compatriots framed alcoholism as a significant public health problem that demanded federal action.

Hughes had had extensive problems with alcohol when he returned from World War II, but he recovered with the help of AA in the early 1950s. He was elected governor of Iowa in 1962 and was reelected in 1964, despite the publication of a high-profile article chronicling his history of alcoholism (Knebel 1964). Hughes spoke at the Democratic National Convention of 1964, won a vacant Senate seat in 1968, and became a vocal critic of the Nixon administration and the Vietnam War (Hughes 1997; Hughes and Schneider 1979). During his first year in office, Hughes saw an opportunity to “piggyback on the drug issue” (Olson 2003, 16). With the support of Senator Ted Kennedy (D-MA), Hughes privately financed a Special Subcommittee on Alcoholism and

Narcotics under the Senate Committee on Labor and Public Welfare. Although Hughes's subcommittee dealt with drug abuse legislation, it played a stronger role in the formation of alcoholism policies. This began in the summer of 1969, when the subcommittee held prominent hearings throughout the country, giving Marty Mann, Bill Wilson, Seldon Bacon, and other members of the alcoholism movement a chance to call for federal leadership (Olson 2003, 40–53; US Senate 1969).

Following the subcommittee hearings, Peter Hutt (the lawyer who litigated the public intoxication cases) drafted authorization legislation for a federal alcohol agency, in close consultation with Nancy Olson and other members of Hughes's staff. Introduced in May 1970, the Comprehensive Alcohol Abuse and Alcoholism Treatment, Prevention and Rehabilitation Act (S. 3835) defined "alcoholism" as "any condition characterized by the repetitive use of alcohol to an extent that causes the drinker physical, psychological or social harm." The bill designated alcoholism as a disease for the purposes of the federal government, and it contained a provision that would have denied federal subsidies for hospitals that discriminated against alcoholics. The main portion of S. 3835 would have established a national alcohol institute somewhere in the Public Health Service, even though Hughes and his staff wanted to place it in the National Institutes of Health (Olson 2003, 62–67). Later versions of the bill authorized \$80 million, \$125 million, and \$190 million for individual project and state formula grants for 1971 through 1973. This covered service programs, and the bill also authorized unspecified appropriations for intramural and extramural research.

From the beginning, the Nixon administration's response was lukewarm. Nixon generally did not want to create new categorical programs, and he viewed NIMH officials as bureaucratic holdovers from President Johnson's Great Society programs. NIMH officials welcomed the budgetary expansion that would accompany the new alcohol programs, yet they worried that the alcohol institute could be used to disperse NIMH's programs throughout the U.S. Department of Health, Education and Welfare (US DHEW) (Chafetz 1976, 111; Olson 2003, 86–87). In an effort to outmaneuver Hughes, the secretary of DHEW elevated NIMH's alcoholism center to the Division on Alcohol Abuse and Alcoholism (DAAA) on July 21, 1970, two months after Hughes introduced his bill (Jones n.d.). To further complicate matters, the alcoholism movement was not especially fond of Morris Chafetz, the director of the DAAA and the likely director of the new institute. A professor

of psychiatry at Harvard Medical School, Chafetz served on the AMA's alcoholism subcommittee, and he ran a large alcoholism program at Massachusetts General Hospital. Nevertheless, Chafetz invited controversy in 1966 when he argued that alcoholism was a symptom of underlying social and psychological problems and that "there is no such thing as an alcoholic" (Chafetz 1966, 810). This raised flags in the alcoholism movement because it approximated the psychoanalytic understanding of alcoholism that it was trying to discredit.

Hughes's subcommittee and the House Subcommittee on Public Health and Welfare held hearings on S. 3835 in May and September 1970, respectively. Advocates for alcoholics used the opportunity to drive home the point that alcoholism was a substantial public health problem. Hughes began the Senate hearings by asserting that alcoholism and alcohol abuse had "long been swept under the rug," even though they impacted roughly 50 million Americans and cost the country \$7 billion annually. Representatives from the alcoholism movement similarly testified that the federal government needed to mount a serious response to a serious public health problem, a perspective that also was endorsed by the alcohol industry (see US House 1970, 387–98). For example, Luther Cloud of the NCA called alcoholism the country's third largest public health problem, noting that the federal government provided one dollar of treatment for each of the country's alcoholics—a mere "drop in the bucket." Marian Wettrick of the NAAAP claimed that billions of dollars were wasted on lost productivity and the "unproductive arrest and rearrest of alcohol victims." Martin Block, testifying for the AMA, noted a "crying need" for treatment services, and he maintained that alcoholics were "entitled to the same rights and opportunities for treatment accorded other sick people" (US Senate 1970a, 90, 99–100, 103).

Many witnesses lauded the public health significance of NIAAA's authorization legislation. But Hughes and Seldon Bacon from CAS also emphasized that the legislation responded to the complexity of the country's alcohol problems. This position was more consistent with the CCSA's "problem drinking" perspective than the with AA's and NCA's disease-centric perspective. Specifically, Hughes noted that his bill reflected a "multiple approach," which drew on the "best information and guidance we have from medical science, psychology, sociology, psychiatry, hospital administration, rehabilitation experience, and legal wisdom" (US Senate 1970a, 68–69). Bacon lamented the tendency to

“isolate some part of the problem,” which fragmented efforts to provide comprehensive services. In his estimation, narrow conceptions of alcohol problems led to conflicting approaches, and he believed the proposed legislation would help federal and local leaders work together to accomplish a wide range of objectives (US Senate 1970a, 115–18). For Bacon and Hughes, these elements were essential to a successful program, irrespective of how much money was spent.

DHEW officials largely agreed with these sentiments, and Chafetz made an effort to endear himself to the alcoholism movement. For example, Roger Egeberg, the assistant secretary for health and scientific affairs, called alcoholism “one of the most prevalent, destructive, costly, and tragic forms of illness in the United States,” and he pledged that it would be a high priority for the DHEW (US Senate 1970a, 125). Chafetz also praised S. 3835 and clarified his previous statements about alcoholism. When Hughes asked if alcoholism was a disease, Chafetz said that he preferred to call it an illness but that he was not “discomfited by the concept of alcoholism as a disease” (US Senate 1970a, 113). This dissipated the tensions with Hughes, but others in the alcoholism movement remained suspicious (Olson 2003, 65; Pike 1979, 273–74).

Nevertheless, administration officials did not want to create a new alcohol institute, and they thought that the bill’s spending levels were overambitious. With respect to the organizational issue, Hughes noted that he was hesitant to place the new alcohol programs in NIMH because most alcoholics did not consider themselves mentally ill and because of the NIMH’s poor track record (Olson 2003, 60; US Senate 1970a, 137). NIMH officials conceded that “psychiatrists and the rest of medicine . . . have not paid adequate attention to this problem” (US Senate 1970a, 141). But they maintained that elevating the alcoholism center to the division level would give the problem the visibility it deserved. Division status would allow the new programs to tap NIMH’s “biological and behavioral science resources,” and it would ensure that its Community Mental Health Centers treated alcoholics (US House 1970, 200–201). On the financial issue, DHEW officials argued that the proposed authorization levels would produce unrealistic expectations. Egeberg thought the DHEW could wisely spend \$6 million in 1971, and he promised that funding levels would increase quickly in subsequent years (US House 1970, 221).

Outside witnesses uniformly asked for more money than the administration witnesses did, but most of them thought the new programs

should be located within NIMH. Cloud, for example, was disappointed by the administration's \$6 million proposal, and John Williams (the director of alcohol programs in New York City) likened it to "slapping a bandaid on a cancerous body" (US House 1970, 333; US Senate 1970a, 91). These and other witnesses thought it was appropriate to spend \$80 million to \$100 million in 1971, the range that Hughes envisioned. Nevertheless, some members of the alcoholism movement disagreed with Hughes on the organizational issue. Cloud testified that visibility was the key issue for NCA: "If divisional status will bring this visibility, if this will make easier the steps which are necessary to implement this, then this is certainly fine" (US House 1970, 291). Marian Wettrick concurred on behalf of NAAAP, and Block relayed the AMA's position that "as important as alcoholism is, it should not be used to set a precedent for creating separate institutes within NIMH" (US Senate 1970a, 102, 104).

Despite widespread support for an extensive federal alcoholism initiative, the passage of authorization legislation faced an uphill battle. The Senate passed S. 3835 on August 10, 1970, but a slightly weaker version did not clear the House until the very end of the congressional session. With no time to convene a conference committee, the Senate passed the House version on December 20. Both the director of the Office of Management and Budget and the secretary of DHEW counseled Nixon to veto the bill. But after behind-the-scenes lobbying from Brinkley Smithers, Thomas Pike, and other influential alcoholics, Nixon reluctantly signed the bill into law at the last possible moment (Pike 1979, 243). The final result (P.L. 91-616) was a compromise between Hughes and the administration. NIAAA became a full-fledged institute, but it remained within NIMH, and most hospitals were not punished for discriminating against alcoholics. Although the final bill authorized \$70 million for 1971, the Nixon administration requested only \$6 million, raising tensions that I discuss below.

Responding to a National Emergency

NIAAA was a congressional initiative to improve public health. The impetus for a massive drug treatment initiative came from within the Nixon administration, however, and its decision to create such a program was driven by a complicated set of motivations. Nixon was genuinely

concerned about the corrosive effects of drugs on American society and was dismayed to learn about high rates of heroin addiction among soldiers in Vietnam. At the same time, he was anxious to appeal to “silent majority” voters, and he thought that drug abuse treatment would lower crime rates in time for the upcoming election. The Nixon administration initially pursued law enforcement and interdiction programs, but the establishment of the Special Action Office for Drug Abuse Prevention (SAODAP) offered a counterpart to these supply-side policies. SAODAP was established by an executive order, placed in the White House, and given unprecedented powers to coordinate demand-reduction programs in federal agencies. After a series of negotiations, Congress authorized SAODAP on a temporary basis and set the stage for the creation of the National Institute on Drug Abuse in 1974.

During the late 1960s and early 1970s, federal drug policies responded to demographic shifts in drug consumption. Rates of heroin addiction rose precipitously during the 1960s, coming to be called a “heroin epidemic” by the end of the decade (see Claiborne 1971; DuPont 1971; Hughes et al. 1972; Johnson 1970; Room 1978, 66–73). At the time, public opinion polls listed crime and drugs as second-tier problems, behind the economy and Vietnam (Musto and Korsmeyer 2002, 39–40). Unlike the marijuana and hallucinogenic drug use that characterized the counterculture of the early 1960s, this new phenomenon involved riskier drugs, and it was blamed for urban crime and poverty. This in turn exacerbated existing concerns about cultural decline and made drugs an important issue for the silent majority.

Nixon’s first response to the heroin epidemic was to pursue supply-reduction policies. Between 1970 and 1971, his administration negotiated an agreement with Turkey (the primary heroin exporter) to ban the cultivation of opium poppies, and it secured a commitment from France (the primary point of passage for heroin shipments to the United States) to crack down on traffickers. At roughly the same time, the Nixon administration worked to reform the drug control policies stipulated in the Daniel Act. After a series of negotiations over scheduling and penalty structures, Congress passed the Comprehensive Drug Abuse Prevention and Control Act of 1970. This law, Nixon’s signature drug control measure, was something of a mixed bag. It eliminated minimum mandatory sentences, made simple possession of all drugs a misdemeanor, increased funding for drug services in NIMH’s Community Mental Health Centers, and added nuance to the regulation of illegal drugs. At the same

time, it gave the Justice Department much more authority than the DHEW over decisions about how to schedule illegal drugs, instituted “no-knock” search warrants, and substantially increased the number of federal drug control agents. As historians David Courtwright and Joseph Spillane suggest, the Control Act was a “big tent” reform. It liberalized earlier drug control laws while expanding and consolidating law enforcement efforts (Courtwright 2004; Musto and Korsmeyer 2002, 42–71; Spillane 2004). In an effort to appear tough on drugs, administration officials emphasized the latter while downplaying the former.

Given the limitations of the Lexington Narcotics Hospital and the civil commitment program, cities and states developed their own programs for heroin addicts. In 1963, New York became the first city to operate a methadone clinic, which was affiliated with New York’s Beth Israel Medical Center and directed by Vincent Dole and Marie Nyswander. Dole and Nyswander viewed heroin addiction as a permanent condition, underwritten by irreversible metabolic changes, so they indefinitely maintained patients on stable doses of methadone to prevent the acute symptoms of withdrawal (Courtwright 1997; Dole and Nyswander 1967; Schneider 2008). This marked a significant departure from earlier forms of maintenance, which used morphine or heroin, and it deviated from the standard practice at Lexington, where decreasing doses of methadone were used to detoxify patients over the course of a couple of weeks. Methadone maintenance was criticized by law enforcement officials, physicians, psychiatrists, and community leaders, who raised concerns about methadone diversion and argued that it merely replaced one addiction with another (AMA Committee on Alcoholism and Drug Dependence 1967; Myerson 1969; Raspberry 1969). Supporters of methadone maintenance countered that it reduced addicts’ cravings for heroin, did not make addicts euphoric, and helped them hold jobs and stay out of jail (Dole and Nyswander 1965; Dole, Nyswander, and Warner 1968; DuPont and Katon 1971). Even though methadone maintenance continued to be controversial, it quickly spread to other cities.

Programs in Chicago and Washington, DC, profoundly influenced the Nixon administration’s thinking about drug treatment. At the end of 1965, the governor of Illinois created the Illinois Drug Abuse Program (IDAP), and Jerome Jaffe was selected to run it. Jaffe had previously completed a clinical internship at Lexington before moving to the Albert Einstein College of Medicine, where he studied the pharmacology

of opiate antagonists. While in New York, Jaffe familiarized himself with Dole and Nyswander's work and also visited Daytop Village on Staten Island to learn how therapeutic communities treated drug addiction. Under Jaffe's leadership, IDAP quickly established a methadone maintenance clinic, a therapeutic community, and a detoxification center. Jaffe defended his "multimodality" approach by arguing that drug addicts were a diverse group of people who needed a variety of treatment approaches. By the end of 1970, IDAP was running sixteen facilities that served about nine hundred patients (Massing 1998, 90–94). At roughly the same time, members of Congress and municipal officials became increasingly concerned about the profusion of drugs and crime in the District. In March 1969, Senator Joseph Tydings (D-MD) held a series of hearings on issue, which led to the creation of the Narcotics Treatment Authority (NTA) the following February. NTA was directed by Robert DuPont, who completed a fellowship at NIMH before becoming a counselor in the District's prison system. DuPont modeled NTA on the New York and Chicago programs. Four months after it was created, his program was serving fifteen hundred patients, most of whom received methadone maintenance or detoxification on an outpatient basis (US Senate 1970b, 2798). During 1972, NTA operated thirteen outpatient and three inpatient facilities (Burt [1979] 2011, 21–31).

Crime reduction was a central part of Nixon's platform in the 1968 presidential election, and he was eager to demonstrate progress on the issue in time for his reelection campaign. Nixon took a keen interest in Washington's crime rate because law enforcement had always been a local issue, but at that time the District lacked home rule. In the beginning of 1969, Nixon reorganized the courts, appointed new judges, and expanded the police force. These reforms, however, had virtually no effect on crime. White House aide Egil "Bud" Krogh was assigned to fix the problem, and he quickly learned about the relationship between drugs and crime established during the Tydings hearings. In January 1970, Krogh met with DuPont, who told him about research showing that methadone maintenance reduced crime. Shortly thereafter, Krogh's staff traveled the country to learn more about the treatment of heroin addiction (Massing 1998, 97–102).

White House advisers soon discovered that Jaffe was highly regarded, and they thought his multimodality approach was pragmatic and politically savvy. In October 1970, Nixon requested two internal reports on how to run a national drug treatment program. One was prepared

by Jaffe and the other was prepared by Bertram Brown, the director of NIMH. Brown's report was couched in the language of psychoanalysis and was critical of methadone maintenance. Brown argued that drug addiction was caused by social alienation so it was best addressed through fundamental social change. He downplayed the significance of the heroin epidemic and called for a commensurately experimental response led by NIMH (Brown 1970). Jaffe's report, by contrast, emphasized the need for immediate action, was critical of psychotherapy, and viewed methadone maintenance as essential to a multimodality approach. Jaffe considered drug addiction a serious problem that could be tackled in its own right, and he called for an expansive federal treatment program. Nixon already was skeptical of the psychiatric profession, distrusted NIMH, and wanted a high-profile program that would quickly reduce crime, all of which inclined him to Jaffe's approach (Musto and Korsmeyer 2002, 77–87).

Nixon sat on the Jaffe and Brown reports for several months, but then the issue resurfaced in April 1971 when Congressmen Robert Steele (R-MI) and Morgan Murphy (D-IL) traveled to Vietnam to investigate drug addiction in the military. In a series of high-profile press conferences, Steele and Murphy reported that 10 to 15 percent of U.S. servicemen were addicted to heroin, which was cheap and plentiful in Southeast Asia (see *GI Heroin Epidemic* 1971). Their findings raised serious doubts about the Vietnam War and its domestic consequences. This created a public relations problem for the Nixon administration, so Nixon called Jaffe and his senior staff together to discuss the issue.

Behind closed doors, Nixon and his senior staff expressed a variety of concerns about drugs.¹ Nixon was worried that the focus on addiction in the military would make the public blame the Vietnam War for domestic drug abuse. He wanted the country to know that most addicted soldiers had used drugs before they arrived in Vietnam and that there was a higher proportion of drug users at Harvard than in the military. He didn't want people to "keep their children out of the service in order to keep them out of drugs," and he wanted to be "sure that we don't destroy the chance of veterans to come home and live [good] lives." Nixon and his advisers also worried that "people who were trained in the military would come back to the U.S. addicted and would use the skills they learned in the military to wreak havoc in the United States" (Jeffery Donfeld, quoted in Musto and Korsmeyer 2002, 51). Nevertheless, Nixon's concerns were not limited to Vietnam. He believed that drugs had a corrosive effect

on American society, saying, "If you look at society and at civilizations over the years, you show me one that became substantially addicted to drugs and I'll show you one that was virtually destroyed by addiction." He felt he had a "responsibility for the future character and strength of this country" and worried that young people "from the so-called better classes" were moving from the "straight society" to the "drug society." Nixon was distressed that heroin addiction was no longer just a problem for nonwhite, urban adults but was beginning to spread to white, affluent, suburban youths. And he firmly believed that black heroin addicts were overwhelmingly responsible for high rates of urban crime.

Nixon's position was "All of us must have compassion for the individual who becomes addicted . . . but we should have nothing but an absolutely hard line with regard to the pushers [and those] who make money out of it." SAODAP was the compassionate side of his drug policy, and Krogh and Jaffe counseled him on the principles that should guide it. In Jaffe's view, drug addiction was a complex condition. It spread like an infectious disease, and like chronic diseases, it could not be cured by a single round of treatment. Accordingly, SAODAP "needed the flexibility to follow the problem" and needed to support community-based programs that delivered a variety of therapeutic services. Such programs would help clients break the cycle of addiction, even if they were unable to completely prevent occasional relapses. As Nixon put it, "The goal . . . is not necessarily to make a man drug-free but to make him a job-holding, law-abiding, tax-paying citizen." At the same time, Krogh stressed that a "collateral goal is to be able to say that no one had to commit a crime because treatment was not available to him."

With this counsel in mind, Nixon created SAODAP with an executive order on June 17, 1971, and he placed Jaffe at the helm. In the accompanying speeches, Nixon declared that drug abuse was "America's public enemy number one" and that it was necessary to "wage a new, all-out offensive" (Nixon 1971a). He proposed \$155 million for the new office, which would be given responsibility for federal prevention, education, treatment, rehabilitation, training and research programs. Nixon regarded this as an "emergency response to a national problem," so he established SAODAP on a temporary basis (Nixon 1971b).

Between July and September of 1971, various congressional subcommittees held hearings on authorization legislation for SAODAP. These hearings were marked by provocative language and causal connections

between drugs and crime. For example, John Ingersoll, director of the Bureau of Narcotics and Dangerous Drugs, testified that “America cannot afford to underestimate the urgency of the current drug crisis, nor can it afford to delay or compromise its response” (US House 1971, 264). Jaffe similarly argued that the “explosion in availability of heroin and the epidemic numbers of people using heroin” required urgent and unprecedented action (US House 1971, 183). Senator Jacob Javits (R-NY) noted that narcotics-related deaths in New York City had increased from two hundred to one thousand per year over the past decade, and he blamed addicts for much of the city’s crime (US Senate 1971a, 6). Not surprisingly, some of the more sensitive issues discussed behind closed doors were not aired in public. Many acknowledged that drug addiction was an urban phenomenon. But few suggested that it would spread to the suburbs, and issues of race and class were barely mentioned at all (US Senate 1971a, 301–5, 409–10).

Jaffe’s testimony laid out the rationale behind the administration’s plans. The establishment of SAODAP represented, in his view, the “realistic and more humane attitude that every addict in need of treatment should be able to obtain it.” Placing SAODAP in the White House and giving it the authority to redistribute funds between agencies that ran demand reduction programs would allow it to effectively and efficiently mobilize the resources of the federal government. After drug programs were better coordinated and the emergency had passed, SAODAP’s functions would be transferred to the DHEW (US House 1971, 172–73, 183). Jaffe also praised Nixon’s proposal because it gave SAODAP the “range and flexibility to realize and to view this problem in its full complexity.” He noted that drug abusers were a heterogeneous population and that experimental drug use differed from the compulsive use of hardened addicts. The diverse patient population would need a variety of treatment options, and SAODAP was in the best position to create a “harmonious whole” that allowed patients to switch modalities without interrupting their treatment (US House 1971, 173, 176–77, 186, 188, 214).

Despite widespread agreement about the need to consolidate federal drug abuse programs, the administration and congressional Democrats had different ideas about SAODAP’s authorities. On June 30, 1970, Harold Hughes introduced alternative authorization legislation for SAODAP. Hughes’s bill gave it authority over agencies that ran law enforcement and interdiction programs. The bill also authorized the

immediate creation of a National Institute on Drug Abuse and Drug Dependence within the DHEW, which would channel most of the treatment funds through NIMH's Community Mental Health Centers. Jaffe took issue with these components of Hughes's bill. He defended Nixon's decision to exclude supply-side programs by citing tensions between law enforcement officials and members of the medical and scientific community and by arguing that his credibility would be tarnished by associating with the former (US Senate 1971b, 342–43). Jaffe also rejected the idea of relying exclusively on Community Mental Health Centers—SAODAP needed the flexibility to use many types of facilities, such as Veterans Administration hospitals and storefront clinics (US House 1971, 218–22). Other administration officials objected to the immediate establishment of a national drug institute because the resultant administrative problems would impede an expeditious response (US Senate 1971b, 99).

Ultimately, the administration got most of what it wanted: SAODAP would have no authority over supply-side programs, and a national drug institute would be created only when SAODAP was about to expire. Many agencies would fund demand reduction programs, but NIMH would act as the lead agency for treatment services. On March 21, Congress passed the Drug Abuse Office and Treatment Act of 1972, which authorized SAODAP for three years and set the stage for the creation of NIDA in 1974. Unlike NIAAA, SAODAP's creation was a foregone conclusion.

Rolling Out Alcohol and Drug Programs

By 1972, Congress had authorized the creation of new federal agencies to administer treatment services for alcoholics and drug addicts. In this section I argue that alcohol and drug programs were not treated equally. The Nixon administration delayed the implementation of NIAAA and tried to cut off funding for alcohol programs. Alcohol experts also had to contend with significant resistance from NIMH. By contrast, SAODAP quickly set to work; drug treatment programs were heavily financed; and drug experts had the power to rebuff minimal opposition from NIMH.

Nixon signed authorization legislation for NIAAA at the beginning of January 1971, and midlevel officials requested final approval from

the secretary of DHEW on February 24 (Wilson 1971). But the decision was delayed and the administration never requested supplemental funds, which were needed because the institute was authorized after the 1971 budget was passed. This angered Senator Hughes, who worked with Morris Chafetz behind the scenes to force the administration to act (Olson 2003, 93–97). On March 18, Hughes's subcommittee held hearings on the issue. Hughes called the administration's inaction a "miscarriage of high executive intent," and he could not believe that the administration was trying to short-circuit a law that served the public interest (US Senate 1971c, 10). Vernon Wilson defended the administration by citing administrative difficulties, and he noted that the alcohol division already was in place and active, although he confirmed that the administration would not seek supplemental funds for 1971 (US Senate 1971c, 21–23, 30–31). Hughes was not satisfied by this response, but the hearings eventually achieved their intended effect. NIAAA was officially created on May 11, 1971, and according to congressional budget justifications, appropriations increased from \$15.4 million in 1971 to \$81.9 million in 1972 and to \$100 million in 1973.

Tensions between Hughes and the Nixon administration resurfaced in 1973 when it was time for Congress to reauthorize NIAAA. The administration's 1974 budget included plans to phase out the institute's project grants for treatment services, and the administration wanted the formula grant program to shift more financial responsibility to state and local governments. Hughes's reauthorization bill, by contrast, essentially maintained NIAAA's existing authorities, and it increased the institute's funding over the next three years. Hughes reacted strongly to the administration's proposal. He was "damn angry . . . at the efforts to destroy . . . the only program we have in this country that has amounted to a darn, to meet the needs of millions of Americans." He complained, "This administration fight[s] every piece of legislation we have brought in here. They have kicked and dragged their feet, and they have tried to cut it back." Hughes also thought that alcohol programs were more worthwhile than billions of dollars spent on the "sterile matériel of war" (US Senate 1973, 19, 22, 29). John Zapp, an assistant deputy secretary at DHEW, relayed the administration's position that the project grants were supposed to be temporary demonstration programs. Reasoning that the programs were successful, Zapp argued that it was time for state and local governments to pick up the costs and that public and private

insurers would start to reimburse for alcoholism treatment services (US Senate 1973, 24–25, 32). Hughes strenuously disagreed with the idea that NIAAA's project grants were demonstration programs, and he used his influence to get the Senate to pass his authorization bill at the end of June. The Nixon administration fought the bill, but the House followed the Senate in January, and the administration eventually backed down. On May 6, 1974, the president signed a reauthorization bill that made NIAAA, NIMH, and NIDA coequal agencies under the newly created Alcohol, Drug Abuse and Mental Health Administration (Olson 2003, 113–17). Hughes and other advocates for alcoholics were satisfied with the final result. But the episode demonstrates that congressional goading was needed to force the administration to act.

Officials at SAODAP experienced none of these implementation and budgetary problems. As mentioned earlier, the office was created through an executive order, and Jaffe immediately began to work on heroin addiction in Vietnam. Jaffe quickly convinced military officials to change their drug policies: instead of court-martialing soldiers who used heroin, soldiers who failed a drug test were forced to undergo a period of detoxification before returning home (Musto and Korsmeyer 2002, 107–12). SAODAP next turned its attention to increasing the number of treatment slots in cities with large populations of drug addicts. Its capacity to act was limited before its authorization legislation cleared Congress in March 1972. But by June 1973, American drug treatment facilities could accommodate roughly 200,000 patients, and SAODAP had implemented a sophisticated data collection system. That year, it operated on close to \$27 million and oversaw the distribution of another \$287 million, almost four times the amount that NIAAA spent during its first full year (SAODAP 1973; SCDA 1973, 73). And in marked contrast to congressional hearings on NIAAA's implementation, hearings on SAODAP's performance elicited positive responses from members of Congress (US House 1973).

Tensions within the executive bureaucracy are harder to document than tensions between the executive and legislative branches. But reflections from NIAAA officials suggest that they encountered substantial resistance from officials at NIMH before the two institutes were placed on equal footing. For example, Morris Chafetz recalled in 1976 that “jockeying for organizational visibility began” immediately after the passage of NIAAA's authorization legislation. The placement of the institute within NIMH “created problems,” and the “leadership of

NIMH . . . jealously guarded” the “prerogatives and perquisites that are marks of power, resources, and position in an organization” (Chafetz 1976, 116). Albert Pawlowski, who ran NIAAA’s extramural research program during the 1970s, also remembered that NIMH essentially treated the institute as a division. According to Pawlowski, “NIMH didn’t like alcoholism . . . they downplayed it all the time [and] treated us badly.” Routine affairs were pocked by “petty stuff” and “little squabbles.” In particular, Pawlowski recollected that NIMH Director Brown asked Chafetz to attend weekly meetings of division directors, which was a “flagrant insult.” NIMH officials bullied Pawlowski to support their initiatives and changed meeting times without informing him (interviews, August 22 and November 10, 2011). Hughes and members of the alcoholism movement remained leery of NIMH throughout the 1970s, and these mundane frictions were no doubt partially responsible (Olson 2003, 105–17, 231–43).

Relationships between SAODAP and the agencies it oversaw seem to have been much smoother, if only because its placement in the White House gave drug experts more power. Jaffe’s ability to rapidly alter military policy is a case in point. But relationships between SAODAP and NIMH also seem to have been relatively free of hostilities. Others have noted that Jaffe complained about Brown’s reluctance to carry out SAODAP directives (Massing 1998, 221–22; Musto and Korsmeyer 2002, 95). In 2007, Jaffe clarified that NIMH favored psychoanalytic therapies and social reforms over methadone maintenance, which created tensions between the two agencies. Then again, he also stressed that “interactions with NIMH were not all about back-stabbing. Without the help of Karst Besteman [the director of NIMH’s drug division] much of the rapid treatment expansion that took place would not have been possible” (Jaffe 2007). Lee Dogoloff, who ran SAODAP’s government services programs, recalled that NIMH officials often viewed drug addiction as a symptom of underlying psychological problems, while officials at SAODAP approached it as a primary condition. Nevertheless, Dogoloff attributed most of the tension to a cultural clash between career civil servants at NIMH (who fastidiously followed bureaucratic procedures) and temporary employees at SAODAP (who wanted to set up treatment facilities as quickly as possible) (interview, August 20, 2011). In any event, there is no indication that these tensions delayed the implementation of drug treatment programs, even the methadone programs that Brown criticized. Ultimately, SAODAP’s placement within the Executive

Office of the President gave it the power to rebuff any opposition it faced from NIMH. In 1975, when SAODAP was disbanded and its authorities were transferred to NIDA, NIDA was already a full-fledged institute under the newly formed Alcohol, Drug Abuse and Mental Health Administration. This meant that drug programs were never really placed under NIMH's authority, giving drug experts a great deal of control over the way they responded to drug problems in the United States.

Conclusion

The creation of NIAAA and SAODAP marked a turning point in American approaches to alcohol and drug problems. Between 1971 and 1974 these agencies delivered hundreds of millions of public dollars to researchers and health care practitioners, signaling the federal government's recognition that science and medicine had vital roles to play in reducing alcohol and drug abuse. In this article I have shown that SAODAP received more authority and resources than did NIAAA, which is somewhat surprising in light of the fact that alcoholism inspired a stronger advocacy campaign than drug addiction. Advocacy campaigns for both alcoholics and drug addicts contained professional components, which closely followed the path taken by advocates for the mentally ill (Grob 1991). Experts created commissions, published authoritative reports, and lobbied for the expansion of government programs. Both campaigns criticized punitive approaches, beseeched the AMA and policymakers to embrace a more sympathetic understanding of people with alcohol and drug problems, and achieved legal reforms that decriminalized public drunkenness and drug addiction. Yet up through the early 1960s, advocates for drug addicts faced fierce resistance from Anslinger and his law-and-order allies. Advocates for alcoholics never faced anything comparable, which gave them a wider window of opportunity to mount a grassroots campaign. NCA drew volunteers from AA's ranks, promoted AA's therapeutic approach, mounted a public information campaign, and established local branches throughout the country. AA never lobbied for public policies, but its efforts to reform alcoholics and its cozy relationship with the popular media made a substantial impact on public opinion while powerful members (such as Brinkley Smithers and Thomas Pike) influenced politicians behind the scenes. The professional and popular branches of the movement formed different opinions

about the nature of alcohol problems, but they came together to expand hospital access and combat moralistic views of alcoholism. These synergistic components made the alcoholism movement stronger than the advocates for drug addicts.

The strength of the alcoholism movement poses something of a historical puzzle. Why weren't they able to achieve more? One way to understand the situation is that even though alcohol programs possessed a stronger lobby and a stronger policy argument (because of the larger number of alcoholics), drug programs mobilized a stronger political argument and attracted stronger political allies. This proved to be a decisive advantage.

Advocates for drug addicts gained momentum during the late 1960s, but Nixon's response to the heroin epidemic was a transformative moment because it was the first time that drug treatment became a major priority for high-ranking officials. The heroin epidemic was considered a national emergency; it tapped into visceral concerns about lawlessness and cultural decline. Nixon's motivations for radically expanding drug treatment services were complicated. The president faced a liberal establishment in Washington, but his election hinged on votes from social conservatives. Nixon feared that drugs were fueling urban crime and that they were a corrupting influence on white suburban children; he felt responsible for addicted soldiers in Vietnam, and he worried about what they would do when they returned home. When experts like Jerome Jaffe and Robert DuPont began to argue that drug treatment reduced crime and encouraged productivity, Nixon saw an opportunity to align good policy with good politics. Drug treatment made sense because it complemented supply-reduction efforts by breaking the habits that created a demand for illegal drugs. It was politically appealing because it united both sides of the political spectrum. On the one hand, Nixon placated liberal congressmen by making treatment the substantive foundation of his drug policy. This was consistent with the Nixon who established the Environmental Protection Agency and the Occupational Safety and Health Administration. On the other hand, he appealed to silent majority voters by pitching treatment as a crime reduction strategy and by highlighting the harsher sections of the Drug Control Act of 1970. This, as historian David Courtwright puts it, amounted to "twenty percent of what the nuts want," and it was consistent with the Nixon who denounced riots, street crime, and communism (Courtwright 2012, 70–95). The political context also explains why the divisive issues of race and

class were barely breached in public: raising them would have invited criticism from liberals and reminded conservatives that urban African Americans would be the primary beneficiaries of drug treatment programs. Much like the rest of Nixon's domestic policy, his drug policy made political sense because it had something for everyone (Conlan 1998, 19–92). Drug programs were the primary beneficiaries of this arrangement. Looking ahead to the 1972 election, Nixon gave SAODAP the money it needed to implement a national treatment system in time to quickly reduce crime. And the placement of SAODAP within the White House gave it enough power to rebuff muted opposition from NIMH.

Meanwhile, the creation of NIAAA was largely justified by the public health needs of a large but circumscribed group of people, along with the argument that the federal government alone possessed the resources and leadership to substantially improve the situation. The alcoholism movement had to rely on Harold Hughes's political savvy and eleventh-hour, behind-the-scenes lobbying from well-connected alcoholics to establish NIAAA over the reservations of the Nixon administration. Even then, NIAAA was left to languish under the burden of ambivalent NIMH bureaucrats. Hughes had to use his subcommittee chairmanship to get DHEW to even implement his legislation, and three years later he fought tooth and nail to ensure that NIAAA was reauthorized. Appearing at the nadir of the Great Society programs, alcohol programs were easily recast as an outmoded form of social engineering, which would enlarge the federal government and was unlikely to solve a long-standing problem. Alcohol programs lacked political allies with direct control over the federal bureaucracy, and they were not easily translated into electoral advantages. This placed them at a political disadvantage and entailed a long and drawn-out process.

Nixon is often credited (or blamed) for initiating the war on drugs. This attribution makes sense in certain respects—after all, the Control Act of 1970 strengthened law enforcement agencies, and Nixon proposed minimum mandatory sentences for heroin traffickers in the months before the Watergate scandal broke. Even so, Nixon's war was fundamentally different from those that followed. Two-thirds of Nixon's drug budget went to treatment, research, and prevention; one-third went to law enforcement and interdiction. This ratio was reversed during the 1980s and 1990s (see figure 2), which, in retrospect, made the Nixon years a golden age for drug treatment.

FIGURE 2. Federal spending on demand and supply programs for drug abuse.

Sources: DAPO 1984, 121–23; ONDCP 1994, 83–85; ONDCP 1998, 13; ONDCP 2004, 51; ONDCP 2012, 13; SCDA 1975, 95.

Irrespective of the ratio between supply and demand programs, federal drug budgets have always been large enough to sustain research and service programs that outpaced comparable programs for alcohol problems (see figure 3). Such disparities can be traced to the establishment of the Lexington Narcotics Hospital in 1935 and the civil commitment program in 1966. Nevertheless, the early 1970s was a transformative moment, when the federal government radically expanded research and service programs and set the stage for future developments. SAODAP initially responded to a national emergency, but the political rationale for drug programs outlived the heroin epidemic. At the time, illegal drugs elicited more public concern than alcohol problems did, which gave politicians an incentive to fund drug programs at higher levels than alcohol programs. This political calculus has remained in place ever since and has had a long-term impact on funding levels.

Although the relative burdens of alcohol and drug problems did not factor into decisions about the size of alcohol and drug agencies when they were created, these types of considerations have been precipitated by the proposed reorganization of NIAAA and NIDA. Scientists at NIAAA

FIGURE 3. Federal spending on alcohol and drug programs.

Source: These figures were calculated on the basis of congressional budget justifications submitted to Congress between 1971 and 2009. The alcohol numbers before 1971 and the drug numbers before 1974 reflect spending at NIMH. All the other numbers reflect spending at NIAAA and NIDA and do not include spending on HIV/AIDS.

have recently argued that the far greater prevalence of drinking more than offsets the higher addictive liability of many (though not all) illicit drugs, resulting in higher aggregate levels of dependence and comorbid psychopathology (Grant, Dawson, and Moss 2011; Knopf 2012). Even accounting for the recent profusion of prescription drug abuse (Paulozzi et al. 2012), this understates the relative burden of drinking because it does not consider alcohol-related accidents and health problems. Of course, tobacco causes far more deaths than alcohol and illegal drugs combined (Mokdad et al. 2005). But in recent years, the relative burdens of different substances have not been reflected in budgetary priorities. According to official estimates of categorical spending in 2009, only about 13 percent of NIDA's budget went to tobacco; an additional 1 percent went to alcohol (NIH 2012).

While NIAAA and its constituents are right to argue that budgetary priorities are out of synch with disease burdens, the history of federal alcohol and drug agencies demonstrates that much more is at stake. I have shown that fears about drug abuse were significant enough to trump not only epidemiological data but also a politically sophisticated

and well-connected advocacy campaign. Social, cultural, and political factors played (and continue to play) an important role in public policy formation. Federal expenditures on alcohol and drug problems reflect deep-seated values, but these types of considerations are overlooked when budgetary priorities are framed solely by quantitative indicators of disease burden. If we wish to have a serious discussion about how to distribute resources between alcohol and drug institutes, politics and culture will need to be part of the conversation.

Endnote

1. The following quotations come from conversations that took place on June 10, 14, and 17, 1971. They can be found on nos. 516-10, 61-1, and 62-1 of the Nixon tapes, available at <http://millercenter.org/scripps/archive/presidentialrecordings/nixon> (accessed March 8, 2012).

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