THE SOCIAL IMPACT OF DRUGS & THE WAR ON DRUGS: The Social Construction of Drug Scares*

Testimony by Craig Reinarman

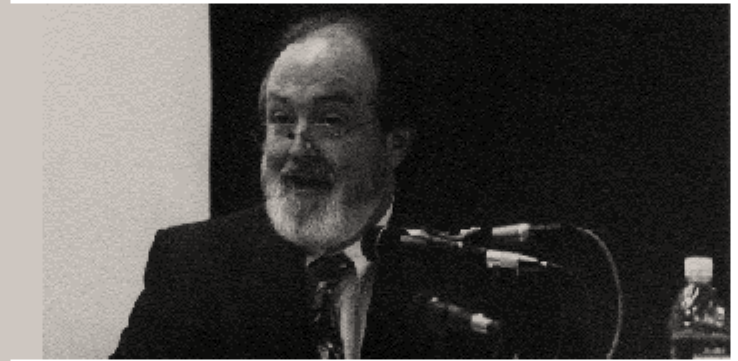
The CIA, the government, and the media in general have gotten away with the kind of shenanigans that you've heard about today, in my view, because of a carefully cultivated anti-drug hysteria. I want to tell you a little bit about that cultivation process. It's a good deal older history, but I think a crucial piece of the puzzle you're examining.

And I should just add that while it is my view that a war on drugs is not the most appropriate, effective, or humane form of drug policy, it is certainly the right metaphor. We have the Army, Navy, Air Force, Marines, Coast Guard, CIA, DEA, FBI, every state level and local police agency, and a network of secret informants, some of whom make up to $500,000 a year, fighting that war.

Drug wars, anti-drug crusades, and other periods of marked public concern about drugs are never merely reactions to the various troubles people can have with drugs. These drug scares are recurring cultural and political phenomena in their own right and must, therefore, be understood sociologically on their own terms. It is important to understand why people ingest drugs and why some of them develop problems that have something to do with having ingested them. But the premise of this testimony is that it is equally important to understand patterns of acute societal concern about drug use and drug problems. This seems especially so for U.S. society, which has had recurring anti-drug crusades and a history of repressive anti-drug laws.

Many well-intentioned drug policy reform efforts in the U.S. have come face to face with staid and stubborn sentiments against consciousness-altering substances. The repeated failures of such reform efforts cannot be explained solely in terms of ill-informed or manipulative leaders. Something deeper is involved, something woven into the very fabric of American culture, something which explains why claims that some drug is the cause of much of what is wrong with the world are believed so often by so many. The origins and nature of the appeal of anti-drug claims must be confronted if we are ever to understand how "drug problems" are constructed in the U.S. such that more enlightened and effective drug policies have been so difficult to achieve.

I want to summarize briefly some of the major periods of anti-drug sentiment in the U.S. and draw from them some of the basic ingredients of which drug scares and drug laws are made. I also want to offer a



beginning interpretation of these scares and laws based on those broad features of American culture that make self-control continuously problematic.

DRUG SCARES AND DRUG LAWS

What I have called drug scares have been a recurring feature of U.S. society for 200 years (*Reinarman and Levine, 1989a*). They are relatively autonomous from whatever drug-related problems exist or are said to exist.[1] I call them "scares" because, like Red Scares, they are a form of moral panic ideologically constructed so as to construe one or another chemical bogeyman, á la "communists," as the core cause of a wide army of pre-existing public problems.

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The first and most significant drug scare was over drink. Temperance movement leaders constructed this scare beginning in the late 18th and early 19th century. It reached its formal end with the passage of Prohibition in 1919.[2] As Gusfield showed in his classic book *Symbolic Crusade* (1963), there was far more to the battle against booze than long-standing drinking problems. Temperance crusaders tended to be native born, middle-class, non-urban Protestants who felt threatened by the working-class, Catholic immigrants who were filling up America's cities during industrialization.[3] The latter were what Gusfield called "unrepentant deviants" in that they continued their long-standing drinking practices despite middle-class W.A.S.P. norms against them. The battle over booze was the terrain on which was fought a cornucopia of cultural conflicts, particularly over whose morality would be the dominant morality in America.

In the course of this century-long struggle, the often wild claims of Temperance leaders appealed to millions of middle-class people seeking explanations for the pressing social and economic problems of industrializing America. Many corporate supporters of Prohibition threw their financial and ideological weight behind the Anti-Saloon League and other Temperance and Prohibitionist groups because they felt that traditional working-class drinking practices interfered with the new rhythms of the factory, and thus with productivity and profits (*Rumbarger, 1989*). To the Temperance crusaders' fear of the bar room as a breeding ground of all sorts of tragic immorality, Prohibitionists added the idea of the saloon as an alien, subversive place where unionists organized and where leftists and anarchists found recruits (*Levine, 1984*).

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This convergence of claims and interests rendered alcohol a scapegoat for most of the nation's poverty, crime, moral degeneracy, "broken" families, illegitimacy, unemployment, and personal and business failure problems whose sources lay in broader economic and political forces. This scare climaxed in the first two decades of the 20th century, a tumultuous period rife with class, racial, cultural, and political conflict brought on by the wrenching changes of industrialization, immigration, and urbanization (*Levine, 1984; Levine and Reinarman, 1991*).

America's first real drug law was San Francisco's anti-opium den ordinance of 1875. The context of the campaign for this law shared many features with the context of the Temperance-movement. Opiates had long been widely and legally available without a prescription in hundreds of medicines (*Brecher, 1972; Musto, 1973; Courtwright, 1982; cf. Baumohl, 1992*), so neither opiate use nor addiction was really the issue. This campaign focused almost exclusively on what was called the "Mongolian vice" of opium smoking by Chinese immigrants (and white "fellow travelers") in dens (*Baumohl, 1992*). Chinese immigrants came to California as "coolie" labor to build the railroad and dig the gold mines. A small minority of them brought along the practice of smoking opium—a practice originally brought to China by British and American traders in the 19th century. When the railroad was completed and the gold dried up, a decade-long depression ensued. In a tight labor market, Chinese immigrants were a target. The white Workingman's Party fomented racial hatred of the low-wage "coolies" with whom they now had to compete for work. The first law against opium smoking was only one of many laws enacted to harass and control Chinese workers (*Morgan, 1978*).

By calling attention to this broader political-economic context I don't want to slight the specifics of the local political-economic context. In addition to the Workingman's Party, downtown businessmen formed merchant associations and urban families formed improvement associations, both of which fought for more than two decades to reduce the impact of San Francisco's vice districts on the order and health of the central business district and on family neighborhoods (*Baumohl, 1992*).

In this sense, the anti-opium den ordinance was not the clear and direct result of a sudden drug scare alone. The law was passed against a specific form of drug use engaged in by a disreputable group that had come to be seen as threatening in lean economic times. But it passed easily because this new threat was understood against the broader historical backdrop of long-standing local concerns about various vices as threats to public health, public morals, and public order. Moreover, the focus of attention were dens where it was suspected that whites came into intimate contact with "filthy, idolatrous" Chinese (*see Baumohl, 1992*). Some local law enforcement leaders, for example, complained that Chinese men were using this vice to seduce white women into sexual slavery (*Morgan, 1978*). Whatever the hazards of opium smoking, its initial criminalization in San Francisco had to do with both a general context of recession, class conflict, and racism, and with specific local interests in the control of vice and the prevention of miscegenation.

A nationwide scare focusing on opiates and cocaine began in the early 20th century. These drugs had been widely used for years, but were first criminalized when the addict population began to shift from predominantly white, middle-aged women to young, working-class, males, African Americans in particular. This scare led to the Harrison Narcotics Act of 1914, the first federal anti-drug law (*see Duster, 1970*).

Many different moral entrepreneurs guided its passage over a six-year campaign: State Department diplomats seeking a drug treaty as a means of expanding trade with China, trade which they felt was crucial for pulling the economy out of recession; the medical and pharmaceutical professions whose interests were threatened by self-medication with unregulated pro-

prietary tonics, many of which contained cocaine or opiates; reformers seeking to control what they saw as the deviance of immigrants and Southern African Americans who were migrating off the farms; and a pliant press which routinely linked drug use with prostitutes, criminals, transient workers (e.g., the Wobblies), and African Americans (*Musto, 1973*). In order to gain the support of Southern Congressmen for a new federal law that might infringe on "states' rights," State Department officials and other crusaders repeatedly spread unsubstantiated suspicions, repeated in the press, that, e.g., cocaine induced African American men to rape white women (*Musto, 1973:6-10, 67*). In short, there was more to this drug scare, too, than mere drug problems.

In the Great Depression, Harry Anslinger of the Federal Narcotics Bureau pushed Congress for a federal law against marijuana. He claimed it was a "killer weed" and he spread stories to the press suggesting that it induced violence especially among Mexican-Americans. Although there was no evidence that marijuana was widely used, much less that it had any untoward effects, his crusade resulted in its criminalization in 1937—and not incidentally, a turnaround in his Bureau's fiscal fortunes (*Dickson, 1968*). In this case, a new drug law was put in place by a militant moral-bureaucratic entrepreneur who played on racial fears and manipulated a press willing to repeat even his most absurd claims in a context of class conflict during the Depression (*Becker, 1963*). While there was not a marked scare at the time, Anslinger's claims were never contested in Congress because they played upon racial fears and widely held Victorian values against taking drugs solely for pleasure.

In the drug scare of the 1960s, political and moral leaders somehow reconceptualized this same "killer weed" as the "drop out drug" that was leading America's youth to rebellion and ruin (*Himmelstein, 1983*). Bio-medical scientists also published uncontrolled, retrospective studies of very small numbers of cases suggesting that, in addition to poisoning the minds and morals of youth, LSD produced broken chromosomes and thus genetic damage (*Cohen et al., 1967*). These studies were soon shown to be seriously misleading if not meaningless (*Tjio et al., 1969*), but not before the press, politicians, the medical profession, and the National Institute of Mental Health used them to promote a scare (*Weil, 1972:44-46*).

I believe that the reason even supposedly hard-headed scientists were drawn into such propaganda was that dominant groups felt the country was at war and not merely with Vietnam. In this scare, there was not so much a "dangerous class" or threatening racial group as multi-faceted political and cultural conflict, particularly between generations, which gave rise to the perception that middle-class youth who rejected conventional values were a dangerous threat.[4] This scare resulted in the Comprehensive Drug Abuse Control Act of 1970, which criminalized more forms of drug use and subjected users to harsher penalties.

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Most recently we have seen the crack scare, which began in earnest not when the prevalence of cocaine use quadrupled in the late 1970s, nor even when thousands of users began to smoke it in the more potent and dangerous form of freebase. In fact, when this scare was launched, crack was unknown outside of a few neighborhoods in a handful of major cities (*Reinarman and Levine, 1989a*) and the prevalence of illicit drug use had been dropping for several years (*National Institute on Drug Use, 1990*). This most recent scare instead began in 1986 when freebase cocaine was renamed crack (or "rock") and sold in pre-cooked, inexpensive units on ghetto street corners(*Reinarman and Levine, 1989b*). Once politicians and the media linked this new form of cocaine use to the inner-city, minority poor, a new drug scare was underway and the solution became more prison cells rather than more treatment slots.

The same sorts of wild claims and Draconian policy proposals of Temperance and Prohibition leaders re-surfaced in the crack scare. Politicians have so outdone each other in getting "tough on drugs" that each year since crack came on the scene in 1986 they have passed more repressive laws providing billions more for law enforcement, longer sentences, and more drug offenses punishable by death. One result is that the U.S. now has more people in prison than any industrialized nation in the world-about half of them for drug offenses, the majority of whom are racial minorities.

In each of these periods more repressive drug laws were passed on the grounds that they would reduce drug use and drug problems. I have found no evidence that any scare actually accomplished those ends, but they did greatly expand the quantity and quality of social control, particularly over subordinate groups perceived as dangerous or threatening. Reading across these historical episodes one can abstract a recipe for drug scares

and repressive drug laws that contains the following seven ingredients:

1. A Kernel of Truth: Humans have ingested fermented beverages at least since human civilization moved from hunting and gathering to primitive agriculture thousands of years ago (Levine, forthcoming). The pharmacopia has expanded exponentially since then. So, in virtually all cultures and historical epochs, there has been sufficient ingestion of consciousness-altering chemicals to provide some basis for some people to claim that it is a problem.

2. Media Magnification: In each of the episodes I have summarized and many others, the mass media has engaged in what I call the routinization of caricature—rhetorically re-crafting worst cases into typical cases and the episodic into the epidemic. The media dramatize drug problems, as they do other problems, in the course of their routine news-generating and sales-promoting procedures (*see Brecher, 1972:321-34; Reinarman and Duskin, 1992; and Molotch and Lester, 1974*).

3. Politico-Moral Entrepreneurs: I add the prefix "politico" to Becker's (1963) concept of moral entrepreneur in order to emphasize the fact that the most prominent and powerful moral entrepreneurs in drug scares are often political elites. Otherwise, I use the term just as he intended: to denote the enterprise, the work, of those who create (or enforce) a rule against what they see as a social evil.[5]

This trinity of media, moral entrepreneurs, and professional interests typically interact in such a way as to inflate the extant "kernel of truth" about drug use...In each of the other scares, similiar conflicts—economic, political, cultural, class racial, or a combination—provided a context in which claims makers could viably construe certain classes of drug users as a threat.

In the history of drug problems in the U.S., these entrepreneurs call attention to drug using behavior and define it as a threat about which "something must be done." They also serve as the media's primary source of sound bites on the dangers of this or that drug. In all the scares I have noted, these entrepreneurs had interests of their own (often financial) which had little to do with drugs. Political elites typically find drugs a functional demon in that (like "outside agitators") drugs allow them to deflect attention from other, more systemic sources of public problems for which they would otherwise have to take some responsibility. Unlike almost every other political issue, however, to be "tough on drugs" in American political culture allows a leader to take a firm stand without risking votes or campaign contributions.

4. Professional Interest Groups: In each drug scare and during the passage of each drug law, various professional interests contended over what Guslield (*1981:10-15*) calls the "ownership" of drug problems—"the ability to create and influence the public definition of drug problem"(*1981:10*), and thus to define what should be done about it. These groups have included industrialists, churches, the American Medical Association, the American Pharmaceutical Association, various law enforcement agencies, scientists, and most recently the treatment industry and groups of those former addicts converted to disease ideology.[6] These groups claim for themselves, by virtue of their specialized forms of knowledge, the legitimacy and authority to name what is wrong and to prescribe the solution, usually garnering resources as a result.

5. Historical Context of Conflict: This trinity of media, moral entrepreneurs, and professional interests typically interact in such a way as to inflate the extant "kernel of truth" about drug use. But this interaction does not by itself give rise to drug scares or drug laws without underlying conflicts which make drugs into functional villains. Although Temperance crusaders persuaded millions to pledge abstinence, they campaigned for years without achieving alcohol control laws. However, in the tumultuous period leading up to Prohibition, there were revolutions in Russia and Mexico, World War I, massive immigration and impoverishment, and socialist, anarchist, and labor movements, to say nothing of increases in routine problems such as crime. I submit that all this conflict made for a level of cultural anxiety that provided fertile ideological soil for Prohibition. In each of the other scares, similiar conflicts—economic, political, cultural, class racial, or a combination—provided a context in which claims makers could viably construe certain classes of drug users as a threat.

6. Linking a Form of Drug Use to a "Dangerous Class": Drug scares are never about drugs per se, because drugs are inanimate objects without social consequences until they are ingested by humans. Rather, drug scares are about the use of a drug by particular groups of people who are, typically, already *percieved* by powerful groups as some kind of threat (*see Duster, 1970; Himmelstein, 1978*). It was not so much alcohol problems *per se* that most animated the drive for Prohibition but the behavior and morality of what dominant groups saw as the "dangerous class" or

urban, immigrant, Catholic, working-class drinkers (*Gusfield, 1963; Rumbarger, 1989*). It was Chinese opium smoking dens, not the more widespread use of other opiates, that prompted California's first drug law in the 1870s. It was only when smokable cocaine found its way to the African American and Latino underclass that it made headlines and prompted calls for a drug war. In each case, politico-moral entrepreneurs were able to construct a "drug problem" by linking a substance to a group of users perceived by the powerful as disreputable, dangerous, or otherwise threatening.

7. Scapegoating a Drug for a Wide Array of Public Problems: The final ingredient is scapegoating, i.e., blaming a drug or its alleged effects on a group of its users for a variety of pre-existing social ills that are typically only indirectly associated with it. Scapegoating may be the most crucial element because it gives great explanatory power and thus broader resonance to claims about the horrors of drugs (particularly in the conflictual historical contexts in which drug scares tend to occur).

Scapegoating was abundant in each of the cases noted above. To listen to Temperance crusaders, for example, one might have believed that without alcohol use, America would be a land of infinite economic progress with no poverty, crime, mental illness, or even sex outside marriage. To listen to leaders of organized medicine and the government in the 1960s, one might have surmised that without marijuana and LSD there would have been neither conflict between youth and their parents nor opposition to the Vietnam War. And to believe politicians and the media in the past six years is to believe that without the scourge of crack the inner cities and the so-called underclass would, if not disappear, at least be far less scarred by poverty, violence, and crime. There is no historical evidence supporting any of this.

In short, drugs are richly functional scapegoats. They provide elites with fig leaves to place over unsightly social ills that are endemic to the social system over which they preside. And they provide the public with a restricted aperture of attribution in which only a chemical bogeyman or the lone deviants who ingest it are seen as the cause of a cornucopia of complex problems.

TOWARD A CULTURALLY-SPECIFIC THEORY OF DRUG SCARES

Various forms of drug use have been and are widespread in almost all societies comparable to ours. A few of them have experienced limited drug scares, usually around alcohol decades ago. However, drug scares have been far less common in other societies, and never as virulent as they have been in the U.S. (*Brecher, 1972; Levine, 1992; MacAndrew and Edgerton, 1969*). There has never been a time or place in human history without drunkenness, for example. But in most times and places, drunkenness has not been nearly as problematic as it has been in the U.S. since the late 18th century (Levine, forthcoming). Moreover, in comparable industrial democracies, drug laws are generally less repressive. Why then do claims about the horrors of this consciousness-altering chemical have such unusual power in American culture?

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Drug scares and other periods of acute public concern about drug use are not just discrete, unrelated episodes. There is a historical pattern in the U.S. that cannot be understood in terms of the moral values and perceptions of individual anti-drug crusaders alone. I have suggested that these crusaders have benefited in various ways from their crusades. For example, making claims about how a drug is damaging society can help elites increase the social control of groups perceived as threatening (*Duster, 1970*), establish one class's moral code as dominant (*Gusfield, 1963*), bolster a bureaucracy's sagging fiscal fortunes (*Dickson, 1968*), or mobilize voter support (*Reinarman and Levine, 1989a,b*). However, the recurring character of pharmaco-phobia in U.S. history suggests that there is something about our culture which makes citizens more vulnerable to anti-drug crusaders' attempts to demonize drugs. Thus, an answer to the question of America's unusual vulnerability to drug scares must address why the scapegoating of consciousness-altering substances regularly resonates with or appeals to substantial portions of the population.

There are three basic parts to my answer. The first is that claims about the evils of drugs are especially viable in American culture in part because they provide a welcome vocabulary of attribution (*cf. Mills, 1940*). Armed with "drugs" as a generic scapegoat, citizens gain the cognitive satisfaction of having a folk devil on which to blame a range of bizarre behaviors or other conditions they find troubling but difficult to explain in other terms. This much may be true of a number of other societies, but I hypothesize that this is particularly so in the U.S. because in our political culture individualistic explanations for problems are so much more common than social explanations.

Second, claims about the evils of drugs provide an especially serviceable vocabulary of attribution in the U.S, in part, because our society developed from a temperance culture (*Levine, 1992*). American society was forged in the fires of ascetic Protestantism and industrial capitalism, both of which demand self-control. U.S. society has long been characterized as the land of the individual "self-made man." In such a land, self-control has had extraordinary importance. For the middle-class Protestants who settled, defined, and still dominate the U.S., self-control was both central to religious world views and a characterological necessity for economic survival and success in the capitalist market (*Weber, 1930 [1985]*). With Levine (1992), I hypothesize that in a culture in which self-control is inordinately important, drug-induced altered states of consciousness are especially likely to be experienced as "loss of control," and thus to be inordinately feared.[7]

Drunkenness and other forms of drug use have, of course, been present everywhere in the industrialized world. But temperance cultures tend to arise only when industrial capitalism unfolds upon a cultural terrain deeply imbued with the Protestant ethic.[8] This means that only the U.S., England, Canada, and parts of Scandinavia have Temperance cultures, the U.S. being the most extreme case.

Some might object that the influence of such a Temperance culture was strongest in the 19th and early 20th century and that its grip on the American *zeitgeist* has been loosened by the forces of modernity and now, many say, postmodernity. The third part of my answer, however, is that on the foundation of a Temperance culture, advanced capitalism has built a postmodern, mass consumption culture that exacerbates the problem of self-control in new ways.

[D]rug scares continue to occur in American society in part because people must constantly manage the contradiction between a Temperance culture that insists on self-control and a mass consumption culture which-renders self-control continuously problematic.

Early in the 20th century, Henry Ford pioneered the idea that by raising wages he could simultaneously quell worker protests and increase market demand for mass-produced goods. This mass consumption strategy became central to modem American society and one of the reasons for our economic success (*Marcuse, 1964; Aronowitz, 1973; Ewen, 1976; Bell, 1978*). Our economy is now so fundamentally predicated upon mass consumption that theorists as diverse at Daniel Bell and Herbert Marcuse have observed that we live in a mass consumption culture. Bell (1978), for example, notes that while the Protestant work ethic and deferred gratification may still hold sway in the workplace, Madison Avenue, the media, and malls have inculcated a new indulgence ethic in the leisure sphere in which pleasure-seeking and immediate gratification reign.

Thus, our economy and society have come to depend upon the constant cultivation of new "needs," the production of new desires. Not only the hardware of social life such as food, clothing, and shelter but also the software of the self—excitement, entertainment, even eroticism—have become mass consumption commodities. This means that our society offers an increasing number of incentives for indulgence more ways to lose self-control—and a decreasing number of countervailing reasons for retaining it.

In short, drug scares continue to occur in American society in part because people must constantly manage the contradiction between a Temperance culture that insists on self-control and a mass consumption culture which-renders self-control continuously problematic. In addition to helping explain the recurrence of drug scares, I think this contradiction helps account for why in the last dozen years millions of Americans have joined 12-Step groups, more than 100 of which have nothing whatsoever to do with ingesting a drug (*Reinarman, Forthcoming*). "Addiction," or the generalized loss of self-control, has become the meta-metaphor for a staggering array of human troubles. And, of course, we also seem to have a staggering array of politicians and other moral entrepreneurs who take advantage of such cultural contradictions to blame new chemical bogeymen for our society's ills.

NOTES

1. In this regard, for example, Robin Room wisely observes "that we are living at a historic moment when the rate of (alcohol) dependence as a cognitive and existential experience is rising, although the rate of alcohol consumption and of heavy drinking is falling." He draws from this a more general hypothesis about "long waves" of drinking and societal reactions to them: "[I]n periods of increased questioning of drinking and heavy drinking, the trends in the two forms of dependence, psychological and physical, will tend to run in opposite directions. Conversely, in periods of "wettening" of sentiments, with the curve of alcohol consumption beginning to rise, we may expect the rate of physi-

cal dependence…to rise while the rate of dependence as a cognitive experience falls"(*1991:154*).

2. I say "formal end" because Temperance ideology is not merely alive and well in the War on Drugs but is being applied to all manner of human troubles in the burgeoning 12-Step Movement(*Reinarmnan, forthcoming*).

3. From Jim Baumohl I have learned that while the Temperance movement attracted most of its supporters from these groups, it also found supporters among many others (e.g., labor, the Irish, Catholics, former drunkards, women), each of which had its own reading of and folded its own agenda into the movement.

4. This historical sketch of drug scares is obviously not exhaustive. Readers interested in other scares should see, e.g., Brecher's encyclopedic work (*Licit and Illicit Drugs (1972*), especially the chapter on glue sniffing, which illustrates how the media actually created a new drug problem by writing hysterical stories about it. There was also a PCP scare in the 1970s in which law enforcement officials claimed that the growing use of this horse tranquilizer was a severe threat because it made users so violent and gave them such super-human strength that stun guns were necessary. This, too, turned out to be unfounded and the "angel dust" scare was short-lived (*see Feldman et al., .1979*). The best analysis of how new drugs themselves can lead to panic reactions among users is Becker (1967).

5. Becker wisely warns against the "one-sided view" that sees such crusaders as merely imposing their morality on others. Moral entrepreneurs, he notes, do operate "with an absolute ethic," are "fervent and righteous," and will use "any means" necessary to "do away with" what they see as "totally evil." However, they also "typically believe that their mission is a holy one," that if people do what they want it "will be good for them." Thus, in the case of abolitionists, the crusades of moral entrepreneurs often "have strong humanitarian overtones"(*1963:147-8*). This is no less true for those whose moral enterprise promotes drug scares. My analysis, however, concerns the character and consequences of their efforts, not their motives.

6. As Gusfield notes, such ownership sometimes shifts over time, e.g., with alcohol problems, from religion to criminal law to medical science. With other drug problems, the shift in ownership has been away from medical science toward criminal law. The most insightful treatment of the medicalization of alcohol/drug problems is Peele (1989).

7. See Baumohl's (1990) important and erudite analysis of how the human will was valorized in the therapeutic temperance thought of 19th-century inebriate homes.

8. The third central feature of Temperance cultures identified by Levine (1992), which I will not dwell on, is predominance of spirits drinking, i.e., more concentrated alcohol than wine or beer and thus greater likelihood of drunkenness.

* This testimony adapted from Reinerman's article in P. and P. Adler, eds., "The Social Construction of Drug Scares," *Constructions of Deviance: Social Power, Context, and Interaction*, (Wadsworth Publishing Co., 1994), pp. 92-103.

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Craig Reinarman is professor of sociology and adjunct faculty in legal studies at the University of California, Santa Cruz and visiting scholar at the Centum voor Drugsonderzoek at the Universiteit van Amsterdam. He has served on the board of directors of the College on Problems of Drug Dependence and as a consultant to the World Health Organization Program on Substance Abuse. Reinarman is the author of *American States of Mind* and co-author of *Cocaine Changes and Crack in America: Demon Drugs and Social Justice.* He has published numerous articles on drug use, law and policy in such journals as the *British Journal of Addiction*, the *International Journal of Drug Policy*, *Addiction Research*, and *Contemporary Drug Problems.*

Honorable Commissioners:

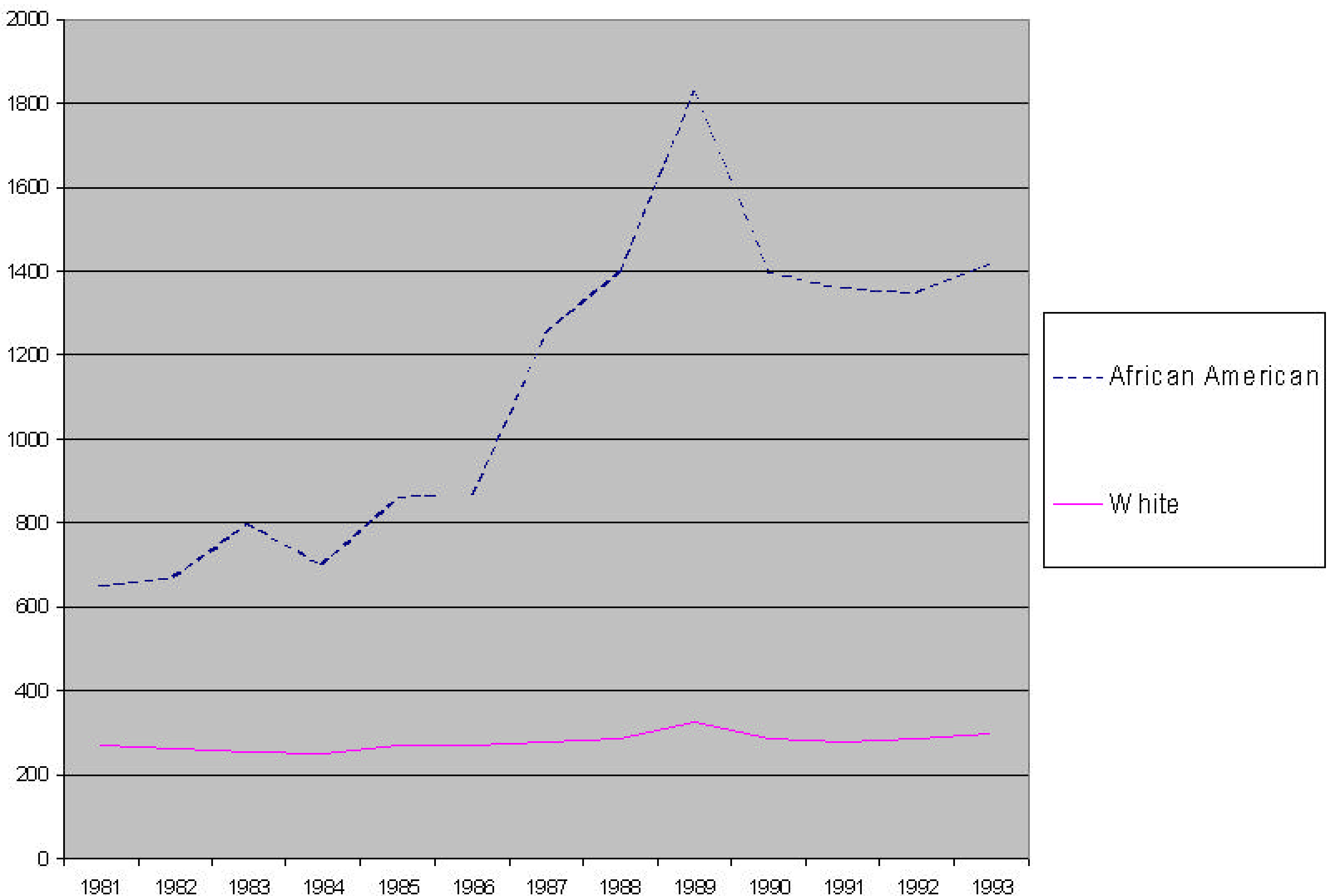
At the close of my testimony before you on May 22nd, you asked if I could provide you with some additional information on federal expenditures for existing drug policy. Herewith please find that information.

1. **Federal 1999 funding for the Office of National Drug Control Policy was $17.1 billion, up from approximately $1 billion in 1981, the first year of the Reagan administration, and from $.065 billion in 1969, the first year of the Nixon administration.** (Sources: *National Drug Control Strategy, 1998*, Office of National Drug Policy, Executive Office of the President, September 22, 1998), p. 55; U.S. Congress, *Hearings on Federal Drug Enforcement Before the Senate Committee on Investigations*, *1975 and 1976*; Office of National Drug Control Policy, *National Drug Control Strategy, 1992: Budget Summary*, p. 214). N.B. These ONDCP budget figures do not represent an accurate total of federal and anti-drug spending as a dozen or more federal agencies have their own direct appropriations for drug policy independent of the funding given them by ONDCP.
2. **In addition to federal spending, anti-drug spending by state and local law enforcement agencies rose from approximately $5 billion in 1986 to approximately $9 billion a decade later.** (Sources: figures prepared by the Bureau of Justice Statistics, U.S. Department of Justice, Feb.7, 1996 for E. Nadelmann, "Drug Prohibition in the United States," *Science* 245: 939-947 (1989); *Anti-Drug Law Enforcement Efforts and Their Impact*, report to the U.S. Customs Service prepared by Wharton Econometrics (1987), pp.2, 38-46; *Sourcebook of Criminal Justice Statistics, 1994* Bureau of Justice Statistics, U.S. Department of Justice. N.B. These increases in state and local spending on drug enforcement appear to have come at the expense of spending on education. For example, while state prison spending rose approximately 30% between 1987 and 1995, state spending on education declined 2% for K-12 and 20% for higher education (Source: National Association of State Budget Offices, *1995 State Expenditures Report;* Washington, DC, 1996).
3. **By 1995, drug law violations accounted for more than 20 percent of inmates in state prisons and local jails and over 60 percent of inmates in federal prisons. These percentages have increased since 1995. The costs of this incarceration ranged from $20,00 to $40,000 per inmate per year (averaging close to $22,000 per year), for a total cost to incarcerate drug law violators of approx. $8.6 billion.** (Sources: Bureau of Justice Statistics, *Jurisdictional Population of Federal Prisons, 1994;* Criminal Justice Institute, *The Corrections Yearbook, 1997* (New York: Criminal Justice Institute); BJS, *Sourcebook of Criminal Justice Statistics*, 1994; BJS, *Profile of Jail Inmates, 1996*, p.1, p.4; see also U.S. General Accounting Office, *Prison Crowding: Issues Facing the Nation's Prison System* (1989).

I hope you find this information useful in your deliberations. If I can be of any further assistance to you, please feel free to contact me.

Sincerely Yours,

Craig Reinarman, Ph.D.
Professor of Sociology and Legal Studies



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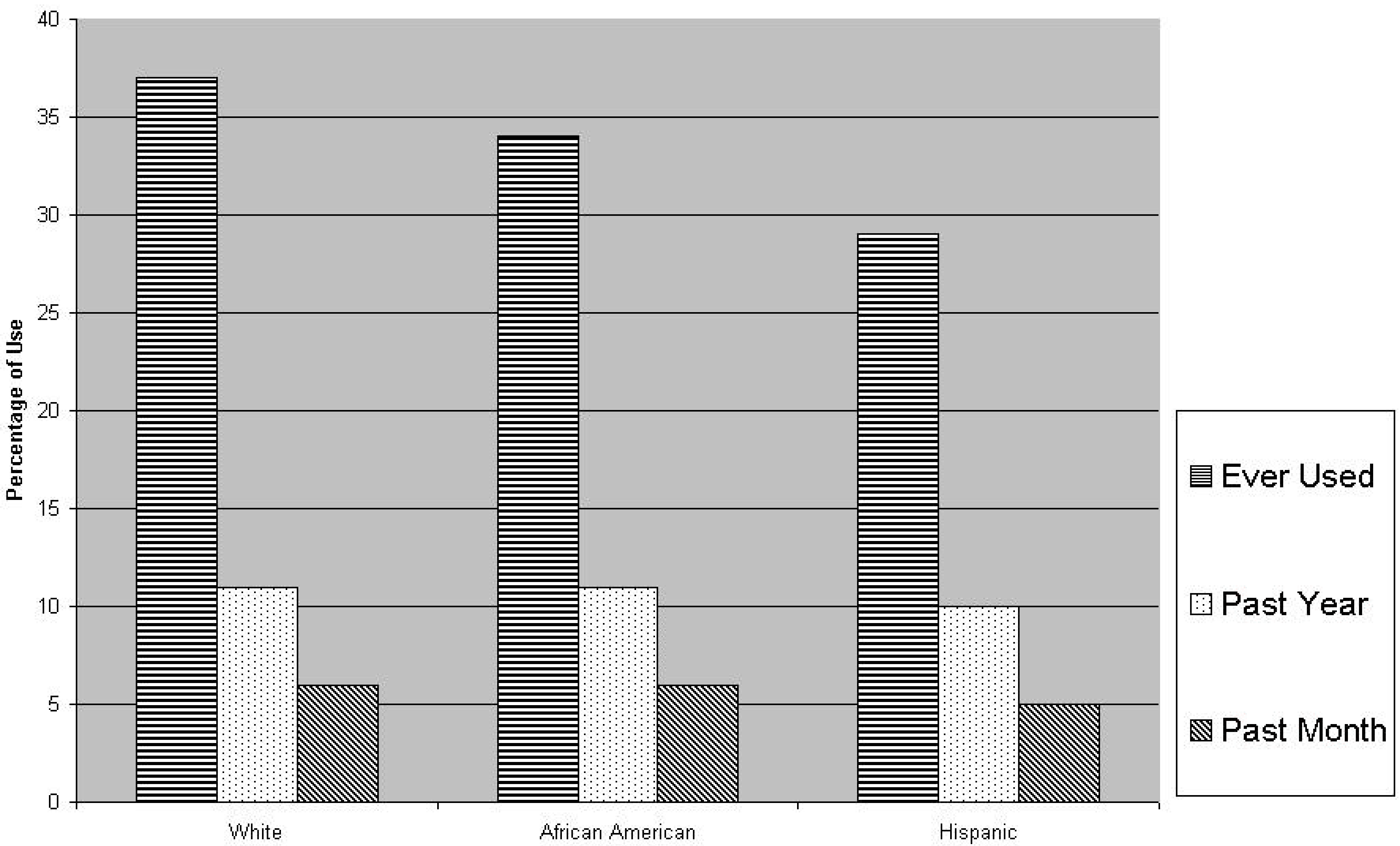
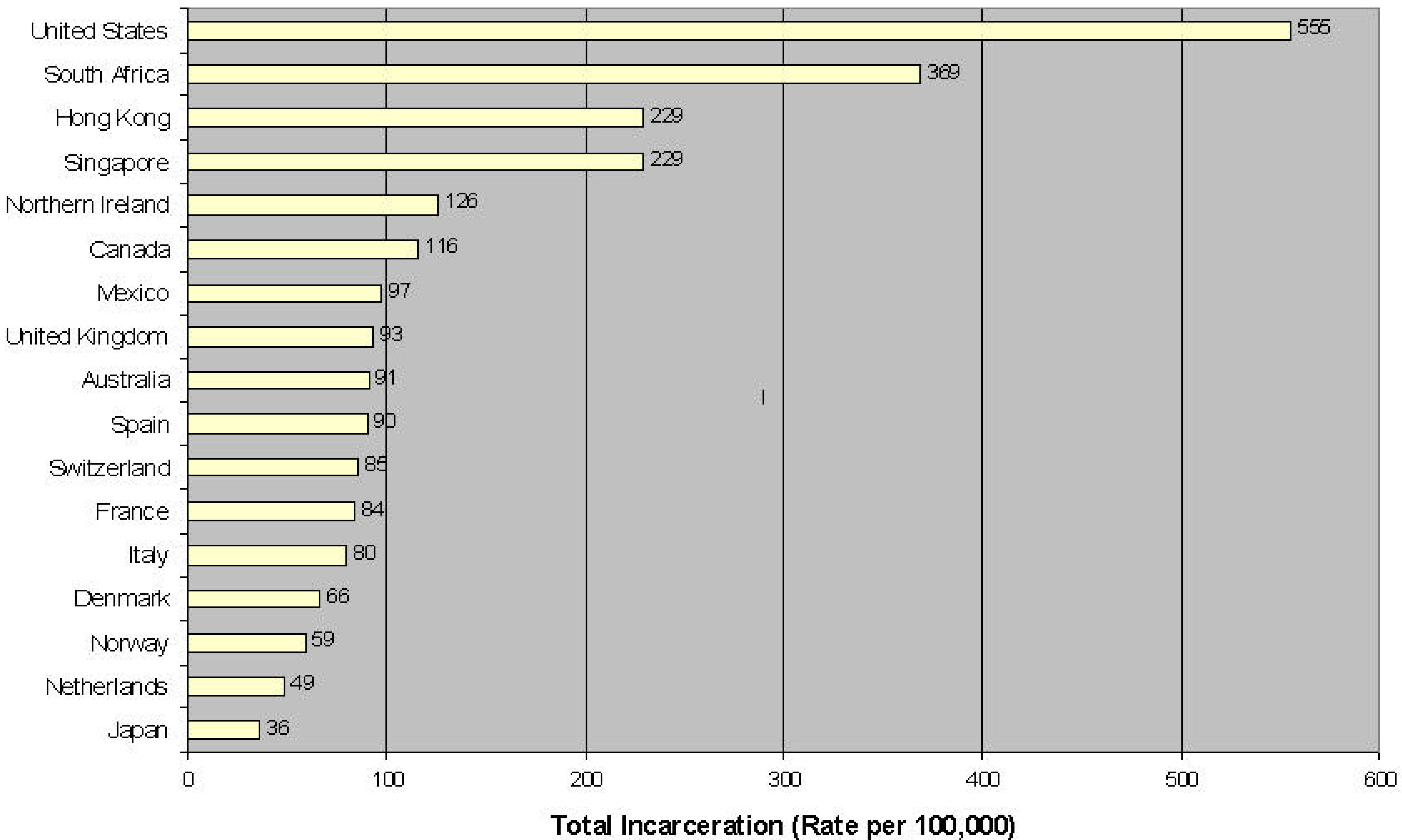


U.S. Illicit Drug Use by Race, 1992
Percentage of Use
40
35
30
25
20
15
10
5
0
White
African American
Hispanic
Ever Used
Past Year
Past Month



Note: Russia's incarceration rate is estimated to be 558; it has been estimated because of questions of reliability. The incarceration rates include both the jail and prison populations.

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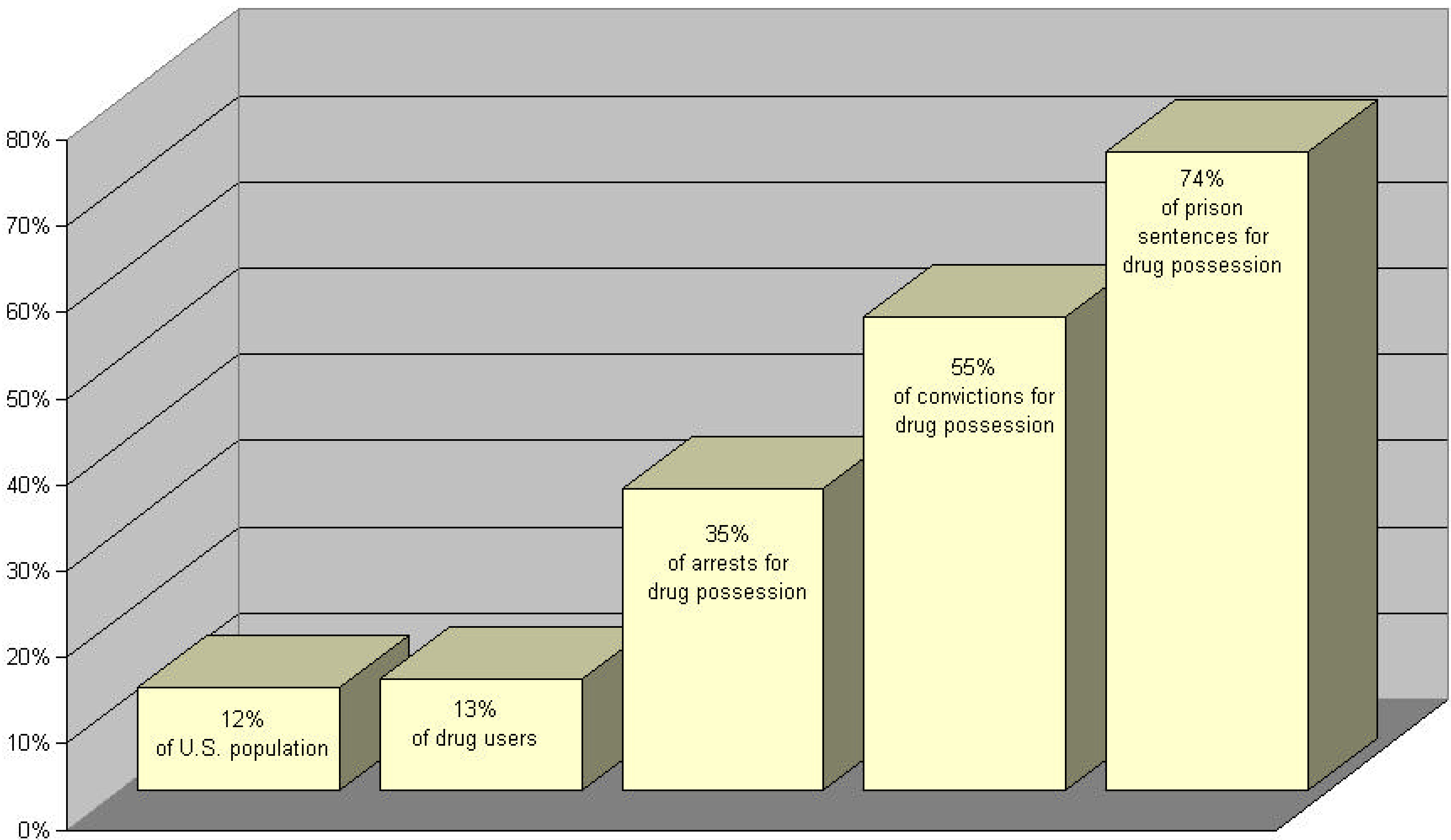
AFRICAN AMERICANS REPRESENT...
80%
70%
60%
50%
40%
30%
20%
10%
0%
12% of U.S. population
13% of drug users
35% of arrests for drug possession
55% of convictions for drug possession
74% of prison sentences for drug possession

THE SOCIAL IMPACT OF DRUGS & THE WAR ON DRUGS: Consquences for Our Communities

Testimony of Karen Bass

It's an honor to speak before you today and I hope the thoughts I have to share are helpful. If you don't mind, I would like to take us back a moment in history and talk a little bit about the whole crack cocaine crisis and what happened in our country and in South Los Angeles. The focus of our work at the Community Coalition is at a neighborhood level. We address questions such as: How do we deal with drugs as they impact neighborhoods? How do we deal with the fact that drugs have compromised the quality of life to such an extent that people have been willing to sacrifice their civil liberties for a little bit of relief? That is the concern that led to the formation of the Community Coalition.

In 1989, our illustrious police chief, Daryl Gates, was trying to emulate our president, George Bush. People probably remember the famous press conference with the bag of crack cocaine and the whole hysteria over crack. One very deep concern that I had as an activist in a number of different movements—and I've been around long enough to have seen several drug wars—has been that in the past, the activist community really didn't pay a lot of attention to the real problems of drugs. The drug wars in the past, in the Nixon years and those that followed, were much more fiction than reality.

Abandoned properties, vacant lots, liquor stores, motels, and recycling centers all play a role in the drug trade.

I think we as activists tended to focus on the U.S. involvement abroad. In the late 1980s, after the Kerry report, everyone knew about the contra connection, but people were not coming up with solutions that were providing relief to neighborhoods. That's the concern that led to Daryl Gates leading what was called Operation Hammer, which were really massive police sweeps, every weekend, of African American and Latino youth in South Los Angeles neighborhoods. So we assumed it was the crack houses that were the cause of alarm for folks in neighborhoods.

We spent several months walking door-to-door doing an extensive needs assessment survey with neighborhood residents. What began to surface was a picture of how the drug trade takes root within an individual neighborhood. That's what I would like to paint for you today. Even though this is a picture that came to light for us just about nine years ago, the picture still exists today. In one of our projects within the Community Coalition, "Neighborhoods Fighting Back," the sole focus is to deal with the drug-related problems within an individual neighborhood.

In each neighborhood you have years of economic and social disinvestment in major commercial strips. The disinvestment also occurs in residential areas, but a lot of it plays out in the commercial strips. Abandoned properties, vacant lots, liquor stores, motels, and recycling centers all play a role in the drug trade. In the recycling center, people can bring cans, bottles, and materials to get small change. The drug dealer will meet you right at the recycling center—literally right at the door of the recycling center. Next door to the recycling center there might be a liquor store where you can buy drug paraphernalia. You can also buy some of the ingredients you need to package and distribute crack cocaine and other drugs. You can buy cheap alcohol and, as you know, one of the things you do to mitigate the effects of cocaine is bring yourself down through the use of alcohol. So it's a very rare addict who's addicted to cocaine; you're addicted to multiple drugs, primarily alcohol.

Motels are overconcentrated in the South Los Angeles area. It's kind of funny because if you drive just south of here, there are about 54 motels concentrated in this area. I guarantee you that no tourists are staying there. These are essentially fronts for prostitution which is completely connected to the drug trade.

The other thing that happens in South Los Angeles is quite fascinating, and we tend to chuckle about it: there are tons of fake businesses. There are lots of store fronts that might say they are selling flowers, but if you walk in the store, there are no flowers. There might be a hardware store, but there are no tools. There might be hamburger stands, but there's no meat. Essentially, these are fake businesses where there is drug trafficking going on. There arealso some affiliated businesses connected to the drug trade such as pawn shops and car lots. There was one car lot that was actually busted. I was wondering how long it was going to take them to get to it. I used to call it the "Crip Car Lot" because they sold luxury cars. You know if you

have a $10,000 transaction, you can't just walk in and pay for something with $10,000. However, at this car lot you certainly could. You could walk in and buy a Mercedes and plop down your cash, and no questions were asked.

So there are a lot of businesses associated with the drug trade. This constellation of activities really compromises the quality of life in several Los Angeles neighborhoods, and this is certainly replicated in inner city communities across the country. Our coalition set out to ask: How can we deal with this? I wanted to raise this question to this panel today. When we're looking at U.S. drug policy, a lot of times we are not looking at it in terms of the neighborhood level. Interestingly, there are a lot of good laws on the books that could be enforced that could improve the quality of life. When everyone is talking about the drug problem, we always get it as an individual situation. So our Coalition has never focused on, and has always opposed, the arrest of individuals.

Sure, you can drive down Figueroa and sweep up all the women if you want to, but given that the women have an addiction that they're feeding, in a few days they'll be back on the street. The interesting thing that we found in South Los Angeles—and, again, this exists in any city—was building and safety codes that hold the landowner and merchants accountable for how they do business. However, in poor inner city areas, the law is just simply not enforced. So when we're talking about drug policy, one of the things I think needs to be factored in is straight out economic development. If you could change some of the commercial activity to make it productive commercial activity, that helps address the drug problem: you have jobs, and you also eliminate these cluster locations.

We had the ironic situation in 1992, when the civil unrest destroyed 200 liquor stores in a three day period. It was fascinating to us that we had to wage a huge campaign to fight the rebuilding of liquor stores. Just compare that to 1994 when the earthquake happened in the Valley—it happened in South Los Angeles too. However, South Los Angeles just didn't get the publicity: no one had trouble understanding that if a problem is destroyed either by an act of nature or an act of man, why would you rebuild the problem? Why would you bring it back?

When we organized residents and went to City Hall, we were essentially treated as though we were the arsonists. How dare we raise the idea of building something else when we were the ones who destroyed those liquor stores? Where we were coming from was to say, okay, this is a tragedy that happened, but let's take advantage of that tragedy and turn it into something positive. We were actually able to prevent the rebuilding of 150 out of the 200 stores. And 44 new businesses came in. As a matter of fact, one is located right near here. There was a store that was burnt right on Vermont that was a source of trouble to the University because members of fraternities went over and really abused alcohol, in addition to the neighborhood drug traffickers and alcoholics and addicts. We fought hard for that store not to be rebuilt and what was built instead is a very nice commercial property. You know, eight or nine years ago, it was a pit. So, I think when we are looking at addressing drug policy, we need to figure out how we can address impact in the local neighborhoods where people are suffering on a day to day basis.

[T]here are a lot of businesses that are associated with the drug trade. This constellation of activities really compromises the quality of life in several Los Angeles neighborhoods, and this is certainly replicated in inner city communities across the country.

Questions From Commissioners

Q: I have seen evidence in larger cities such as Chicago, New York, and Cleveland, where entire city blocks have been abandoned to drug sellers because they are simply too dangerous for the police to go in unless they go in force. Are you aware of any such situation here in Los Angeles?

A: Oh, absolutely. I do not understand why you cannot use the power of eminent domain to take land and put something positive on it. My organization is involved in a development project, and I've been traveling to other cities. Last week at this time I was in Harlem, and I was just amazed. I'd been to Harlem ten or twelve years ago, and I knew what Harlem looked like. There's been a massive effort there to redevelop Harlem; some of those blocks have been completely turned around. The way they were turned around was through the use of eminent domain. Because the fact of the matter is, these absentee landlords are allowing property to go downhill. In South Los Angeles, you have absentee landlords and they own little pieces of land, so you can't accumulate a large enough land mass to do a decent development. But the creative use of eminent domain in the major commercial strips allows community-based organizations to develop land. In the case of New York, a lot of churches are responsible for the development. I think it's just such an irony that

in New York, you have Mayor Guiliani who took charge and changed Manhattan, but he let the people deal with Harlem. The people are doing a wonderful job, but I think you understand my point: government abandoned the inner city, but was proactive when it came to Manhattan.

Karen Bass has been an activist working for social change in Los Angeles for 25 years. She was active in the anti-apartheid movement and, after watching the devastation caused by crack cocaine, felt compelled to "do something" about the problem. Bass formed the Community Coalition For Substance Abuse Prevention & Treatment to seek an alternative to a law enforcement-focused response to drug and alcohol problems. The Coalition brings together African American and Latino neighborhood activists, social service providers, youths, recovering addicts, and church leaders and congregations. The goal of the different component projects of the Coalition is to clean up South Los Angeles neighborhoods, develop a new generation of young activists, and increase resources for prevention, treatment and recovery. Bass is also a Clinical Instructor at the USC School of Medicine, Physician Assistants Program.

THE SOCIAL IMPACT OF DRUGS & THE WAR ON DRUGS: Race, Class, and Public Health

Testimony of Carrie Broadus

While working in community-based organizations, one of the things that we have learned is that we are more than just a body: we are mind, body, and spirit. While the judicial system only sees right and wrong, human beings are mind, body and spirit, and will not be guided by a rigid legal system. I want to focus on what this means in communities in terms of the war on drugs, particularly around injection drug use, and substance abuse as it relates to the spread of HIV, AIDS and other communicable diseases.

In African American and Latino communities, which are largely segregated neighborhoods, we often find that in trying to develop harm reduction programs, particularly around exchanges of syringes, the police move in, confiscate syringes, and arrest people. Even though there are more whites who inject drugs, it is frequently Latinos and African Americans who pay a heavier price, including ending up with HIV and AIDS.

The lifetime cost of taking care of someone with HIV/AIDS is, with new medications, up to almost $156,000 per patient. By contrast, a needle exchange program is approximately $12,000 per year for 500 to 1,000 injection drug users. Yet we do not rid our books of the paraphernalia laws. I think that's where we need to start. How do we eliminate the paraphernalia laws that impede our ability to promote and provide sound public health practices? More than a half dozen scientific studies have shown that needle exchange programs do not promote drug use, yet we still have laws on the books that say it is against the law to have a syringe if you do not have a prescription.

We need to talk about race, as well. In St. Louis, where you can purchase a syringe from a pharmacy in most instances, pharmacies will not sell syringes to African Americans and Latinos. So the issue about drugs is about race. The issue about drugs is also about how we continue to not support harm reduction programs. We support making sure that motorcycle drivers wear helmets. We make sure that all of the waitresses and the cocktail waitresses do not have to inhale secondary smoke in restaurants and hotels. We tell the individual who is smoking ten packs of cigarettes a day to cut down to one pack and eventually eliminate the consumption of tobacco. But when it comes to harm reduction for drug users, we don't use the same logic. We must look also at what effect this attitude has on our youth.

In South Central Los Angeles, in a methadone clinic, young individuals between 16 and 20 start out smok-

ing crack cocaine, but eventually end up shooting heroin or speedballing. We have to begin to look at the fact that the poverty rate among African Americans and Latinos is directly associated with the spread of HIV and AIDS in Los Angeles County. Poverty, race, and poor education, are directly related to HIV transmission.

We are told that Los Angeles County has been very fortunate because the spread of the HIV virus among injection drug users is very low. But I'm willing to challenge that claim, because we have not done adequate surveillance of that population regarding injection drug use. When you begin to look at women of color—African American and Latino women—we find that they are being infected by heterosexual contact. But we have not discovered what that heterosexual contact is. Is it with men who engage in illicit drug use? We don't know. So instead of spending so much money locking up black and brown folks, instead of having community jails popping up in our neighborhoods, we need more primary health facilities and more primary care physicians. The data clearly shows that there are far fewer primary health facilities and physicians in the economiccally disadvantaged black and brown communities that span from east to south cental to southwest Los Angeles.

The lifetime cost of taking care of someone with HIV/AIDS is, with new medications, up to almost $156,000 per patient. By contrast, a needle exchange program is approximately $12,000 per year for 500 to 1,000 injection drug users.

We must begin to look the costs of this discrepancies to mind, body, and spirit. How many jails can we build? We can't build enough. It is far more costly to incarcerate an individual than it is to provide basic primary health care services including harm reduction programs. What we have been able to do within within the

South Central service planning area of Los Angeles County is to begin to look at connecting harm reduction services to the continuum of alcohol and drug treatment, recovery, and aftercare. Often, the substance user in our community is a generational substance user. In other words, in a community that has nothing but oppression, depression, and repression, people can only see what is placed before them, and often, that is drug use. Generational substance users need more than just a pat on the back and carting off to jail. We must find ways to develop the kinds of programs that are committed to harm reduction. That includes exchanging syringes. In addition, we must work towards a comprehensive approach to that population.

We can no longer think in terms of rehabilitation; we must think in terms of habilitation. We can no longer think in terms of the individual; we must begin to think in terms of a community. It is the community that suffers. It is the child who goes hungry because the mother or the father has the monkey on her or his back. It is the mother, it is the woman who has to suffer domestic violence as a result of her addiction. It is the man who also suffers the humiliation of not being able to provide for his family.

It is far more costly to incarcerate an individual than it is to provide basic primary health care services including harm reduction programs.

We must not forget that this is about race. Disproportionate numbers of black and brown people are incarcerated for possessing syringes. When we look at "three strikes" policy, we find that a person who steals a piece of chicken because he's hungry can end up spending twenty years in jail. When we look at the number of white users compared with the black and brown users, who ends up in jail? The black and brown. So for this body, I would like to say that the most that you can do is to look towards changing these laws on paraphernalia and possession so that we can do the work of public health. We must find ways to prevent illnesses and disease, and that includes the illnesses and the disease associated with substance use.

Questions From Comissioners

Q: I have looked at this idea of needle exchange for quite a while. I've been involved in researching all of these issues with regard to drug policy in our country, and I've got to tell you that there are many, many complicated issues in this area, but one of them is not needle exchange. That is really a no-brainer, it is really straight forward and we must do it. Do you know how much a needle and syringe cost in the private sector?

A: A syringe can be purchased for about seven and a half to ten cents. That is the cost associated with conducting a needle exchange. However, I'm sure that with AB518, the proposed state legislation regarding pharmacies being able to provide syringes, we might see that cost driven up. That is one of the concerns as this legislation moves forward: What it will mean for the economically disadvantaged? Another thing to look at regarding needle cost is discarded waste. Some of you might remember, if you're from California, that we used to have bottles and cans strewn across our highways and freeways. I often ask people, "Do you see that now?" And they tell me, "Well, no." The reason is that we placed a value on that discard and we call it recycling. We need to do the same thing in terms of exchanging syringes. Often, the black and brown injection drug user will discard that syringe because when they see the LAPD [Los Angeles Police Department], they know that they could end up in jail because of one syringe.

Q: Can I follow up on the cost? You gathered some figures: $156,000 for treatment and $12,000 for needle exchange. Is that for a year or for a lifetime?

A: That's for one year. The $12,000 is basically to purchase syringes, antibiotic creams, and other types of public health materials. That's $12,000 for a program that services between 500 to 1000 injection drug users.

Q: And what is the $156,000?

A: The $156,000 is the cost of treating one person who is living with HIV and AIDS.

Q: One person for one year?

A: No, one person for a lifetime. What we're talking about is that the federal government is willing to spend three billion dollars to provide service to approximately 25,000 individuals who have contracted AIDS through injected drug use. And the cost is growing, of course, with combination therapy, the expensive cocktails, etc.

Q: Ms. Broadus, about five years ago, we wrote letters to every dean of every medical school in the country recommending that they focus more upon drug addiction in medical school and we got a pretty good response. What is your opinion as to the availability of knowledge in the medical community about the whole addiction issue?

A: It's not the medical community that doesn't understand the issue. In fact, time and time again, it has been the medical community that has lent its support in terms of harm reduction and needle exchange programs. It is the criminal justice system that doesn't get it, and as you said earlier, needle exchange is a no-brainer. Once again, it goes back to race. How is it that we can continue to oppress and depress a community, and do it through the kind of idiotic laws that will cause individuals to not only be incarcerated, but also cause the spread of communicable disease? I haven't even touched upon hepatitis C and B, tuberculosis, syphilis, gonorrhea—all of those can be blood born pathogens as well as airborne. Yet when we look at the opportunity to provide safe, harm reduction messages and public health prevention, we're stopped at every turn by the legal system.

Q: It's my experience that the powers that be say, "Oh, no, to go to a needle exchange program sends the wrong message to children and the rest." But the message that we are sending is that we don't care if you die. We don't care if you provide this devastating disease to your sexual partner and if you're a woman, to your children. If the laws proscribing possession of drug paraphernalia were repealed, would that make it easier for you to distribute the needles?

A: It would help us in terms of exchanging syringes. We don't distribute. The whole issue around exchanging is that we are placing a value on that blood born pathogen carrier. Exchanges are a way to rid our communities of biohazardous waste in a more effective, public health manner that allows us to rid our parks, our playgrounds, our street corners of biohazardous waste.

Carrie Broadus is a long-time community health and environmental advocate with many years of experience working with diverse populations, including persons on public assistance, homeless poly-drug users, lesbians, gays, transgender, bisexuals, heterosexuals, inner-city high-risk youth and persons in transitional living for the post-incarcerated. She works with the Minority AIDS Project (MAP) and is an independent consultant to non-profit community-based organizations on implementing community health planning and program evaluation. She serves as a member of various health advisory groups to Los Angeles County, the State of California and the federal government, and is the First Co-Chair and Public Policy Chair of the African American and Other Drugs Services Advisory Council of Los Angeles County.

THE SOCIAL IMPACT OF DRUGS & THE WAR ON DRUGS: Inequality of Prosecution and Imprisonment

Testimony of Franklin Ferguson, Jr.

The war on drugs has had devastatingly negative effect on equality of social justice. I will concentrate today on the criminal justice sphere. Too often, social phenomena, such as the proliferation of drug use and the criminal activity which is a by-product of the drug trade, is designated by political leaders as being a problem that has either originated within or reached "maximum density" in the inner cities. Once the problem is characterized as such, it is either ignored or else viewed as bearing threatening consequences to non-urban, policy-rendering sectors. In an effort to curb this problem, "urban containment legislation" prevails. As an example, for most states, the largest budgetary outlays target prison construction, while cutting education, health care, and jobs programs.[1]

Closely identified with the urban inner city, there is a significant public perception problem for minority groups.[2] Sadly, this problem may be growing worse even as the level of racism in the system is declining. The problem does not depend on racism, but upon a self-serving, self-perpetuating agenda divorced from actual concern for its constituency. Because I have worked most closely with blacks relative to this phenomenon, I have concentrated my remarks on the experience of black, urban inner-city citizens.

Many have come to believe that because whites disproportionately use powder cocaine while blacks disproportionately use crack cocaine, a two-tiered system of punishment has developed. The disparity between the amount of powder cocaine and crack cocaine required to trigger the same sentence is 100-to-one.

This problem begins not with race but with class. Like a range of other crimes, past and present the drug trade consists of consensual transactions which take place within organized sales and distribution networks. These networks tend to segment by economic class. The rise of crack in the 1980's produced a class divide in the cocaine market that was unusually visible.

A variety of factors have pushed the criminal justice system toward defining the relevant offenses more harshly and enforcing them more consistently against participants in lower-class markets than against their upscale counterparts. These factors are partly retributive: the former are certainly perceived to cause greater social harm than the latter, and therefore seem to deserve harsher treatment. Lower-class criminal markets tend to be more violent than their upper-class equivalents, at least in terms of the manner in which our society typically measures violence. It is easier to catch and punish sellers and buyers in lower-class markets than it is to catch and punish their higher end, white collar counterparts. The lower-class markets are eminently more visible. Lower-class constituents simply possess a much lower expectation of privacy, in direct proportion to their possession of land and property. This does not, however, justify the practice.[3]

Many have come to believe that because whites disproportionately use powder cocaine while blacks disproportionately use crack cocaine, a two-tiered system of punishment has developed.[4] The disparity between the amount of powder cocaine and crack cocaine required to warrant the same penalty for drug trafficking is 100-to-one.[5]

The mandatory minimums continue to be the principal reason why the federal prison population in the United States has swelled to well over one million in recent years, over 130 percent higher than in 1980.[6] The impact of these sentences is compounded by the abolition of parole in the federal system. There are about one hundred mandatory minimum provisions contained in sixty statutes, but 94 percent of all cases are tied to only four statutes concerning drug and weapons charges.[7] These mandatory minimum sentence enhancements "have also resulted in greater use of court resources in responding to low-level drug offenders at the expense of higher level offenders."[8]

The social harms from consensual crime tend to be concentrated in the areas predominated by down-scale markets: i.e., in poor urban neighborhoods. As a result, police and prosecutors tend to focus their attention not on drug crime generally, but on certain kinds of drug crime in certain kinds of neighborhoods. This enforcement strategy, in turn, tends naturally to produce racial or ethnic disparities, since poor urban neighborhoods are so often segregated from neighborhoods of higher economic class along racial or ethnic lines.[9]

It is not a coincidence, accordingly, that blacks constitute 13 percent of America's population but more than half of its 1.7 million prisoners. As of June 1997, the number of inmates in America's prisons and jails was estimated at 1,725,842.[10] A study reported in early 1997 found that, nationwide, 51 percent of prisoners were African American.[11]

The legal system's crusade against crack significantly increased racial disproportions that had been largely stable entering the 1980's.[12] Sentencing differences between crack and powder cocaine are common, and at least at the federal level, they are severe. Sentences in crack cases "average three to eight times longer than sentences for comparable powder offenders."[13] Of the 2,100 federal prisoners serving time for crack, about 92 percent are African American. Of the 5,800 federal prisoners serving time for cocaine powder violations, only about 27 percent are African American.[14]

Even amongst staunch advocates of the black urban poor community, there is support for this apparent disparity in enforcement. The crack trade destroys not only those who engage in it, but also the neighborhoods in which it takes place. Those neighborhoods are filled with predominantly honorable black citizens who do not buy and sell crack. These citizens, it is posited, may benefit from sentencing and enforcement policies that target crack relative to other drugs,[15] since crack's residual, often violent criminal activities are simultaneously targeted.

If African American citizens, however, are the beneficiaries of the penological system's crusade against crack—if the criminal justice system has, in effect, engaged in a kind of large-scale affirmative action for the benefit of urban black neighborhoods—why do those citizens harbor negative feelings about the criminal justice system, suspecting it to have racist implications?[16] Closely related gang-abatement orders, the establishment of drug-courier profiles, and programs such as the Drug Enforcement Administration's "D.W.B" [Driving While Black] or the Operation Pipeline initiative provide heavy taxes to the personal liberties of these same black citizens, irrespective of the places where they reside.

As a group, blacks oppose legalization of drugs, as well as "get tough" law enforcement policies, at least relative to marijuana.[17] Few blacks have confidence in the police or in the criminal justice system; blacks perceive a high level of racism in the system, and these perceptions have not improved over the past twenty years, a time when drug enforcement has increasingly come to dominate the criminal justice system. Blacks and whites alike lack confidence in the criminal justice system as a whole, though the level of distrust is slightly higher for blacks. In a 1996 survey, 22.4 percentof whites and 20 percent of blacks reported having "a great deal" or "quite a lot" of confidence in the system, while 32.8 percent of whites and 35.5 percent of blacks reported having "very little"confidence.[18] When respondents were asked to define their confidence in the court system, blacks were substantially more critical than whites—82.9 percent of blacks versus 64.5 percent of whites had only "some" or "very little" confidence in the local courts. A similar though slightly smaller disparity appeared when respondents were asked to rate their confidence in the prison system.[19]

With respect to the police, blacks are much more negative than whites, irrespective of economic class breakdown. Again, using 1996 figures, 63 percent of whites reported having "a great deal" or "quite a lot" of confidence in the police; only 44.1 percent of blacks did so.[20] Thirty-seven percent of whites reported having only "some" or "very little" confidence in the police, compared with 55.8 percent of blacks who gave responses.

It is not a coincidence…that African Americans constitute 13 percent of America's population, but more than half of its 1.7 million prisoners.

When asked to rate the honesty and ethical standards of police officers in a 1996 survey, 31 percent of blacks answered "low" or "very low," compared to only 8 percent of whites.[21] This disparity has actually grown over the past two decades. A 1977 survey asking the same question found that 21 percent of non-whites and 11 percent of whites gave the police a "low" or "very low" rating on honesty and ethics.[22]

When asked directly whether the system is racist or discriminates against blacks, roughly two-thirds of blacks consistently say yes, and that percentage is fairly constant over time. In 1977, 61 percent of blacks said the criminal justice system discriminates against them in providing protection from crime and 71 percent said the police discriminate against them.[23] In a 1995 Gallup poll, 72 percent of blacks stated that the criminal justice system treats blacks more harshly than whites.[24] In the event that blacks' suspicions are justified, that there has been an oppressive component of drug policy and enforcement over the past twenty years, it is necessary to explain the phenomenon.[25]

The system's treatment of crack relative to other drugs is a kind of paternalism that purports to favor rather than harm African American neighborhoods. But this

paternalism is double-edged: it sends the message that some neighborhoods (and some groups) are subject to different standards than others. Whether that message is racist or not, it appears to be racist. As is quite often the case, perception is reality. Apparently racist enforcement patterns tend to undermine the normative force of the drug laws among targeted groups, to delegitimize the system in the eyes of those whose behavior the system seeks to influence.[26]

More importantly, the privileges and immunities of citizenship, relative to those seemingly targeted groups, are sorely undermined. Tantamount to the situation that developed in the wake of the Civil War, necessitating the development of the various Ku Klux Klan Acts, the federal government has an obligation to calibrate the effects of criminal justice policies gone askew.

For alcohol seventy years ago, as for crack today, law enforcement has tried both to signal that the relevant behavior is wrong and to target the behavior primarily when it is associated with "bad" or outwardly visible, social consequences—violence, disease, impoverishment of children and the like. The targeting seems right, but it undermines the signal. It is very hard to tell people that they should not do something others are tacitly permitted to do, especially when the others in question come from a more favored population group.

Logically, those who trade in crack, if they cause more harm than those who trade in powder, should be punished more harshly. The very nature of the relevant police tactics allow the police to externalize much of the cost of enforcement when they go after the street-level crack trade, in a way that they cannot so easily do when they go after more upscale drug markets. The difference lies in the perceived social costs, or collateral consequences of the criminalized behavior. When the collateral consequences are largely a function of the class and neighborhood in which the behavior occurs, the message becomes: The behavior is bad when people in that class and neighborhood do it.

African American neighborhoods…are subject to different standards…Whether that message is racist or not, it appears to be racist. As is quite often the case, perception is reality.

To succeed, drug enforcement needs to become more self-consciously egalitarian. In plain English, it has to be fair. Moral laws, if they are to succeed, must send the message that the behavior in question is bad and wrong, without regard to the "outwardly measurable" costs, since these are far too subjective to have real worth.[27]

Questions From Commissioners

Q: I think I heard you say that prison population was now 130 percent greater than it was in 1980? If that's what you said, the picture's a lot worse than that, it's 400 percent greater now.

A: I was talking about the federal prison, I'm sorry.

Q: Even the federal prison has gone up 250 percent since 1980.

Q: My question is, I think I heard you say that the black community opposed legalization of drugs, but supported decriminalization of marijuana?

A: I was not clear. In essence, when I spoke about the black community not being in favor of legalization of drugs, that data is only with respect to marijuana because these polls don't ask questions about cocaine, heroin, and so forth, so our data is only limited to what we've asked about which has been marijuana use.

Q: How do you explain that and do you have some suggestions for us as to how we can address that problem, because it came up yesterday as well.

A: Which problem, sir?

Q: The problem that the logical response from the black community should be to treat drugs as a public health problem and not as a criminal justice problem.

A: No, I think there is a two-tiered response to that. Number one, I believe that African American persons do not appreciate the negative ramifications of the drug trade, legalized or otherwise, and I'm not convinced that legalization will get rid of some of the negative impacts of the drug trade. The other part of it, though, as I think Ms. Bass articulated very well and I tried to talk about in my presentation, is the fact that we have the current laws on the books, but we enforce the laws disparately. That's the problem. And that delivers a very poor message because perception is everything. If I'm an employer and I'm hiring, but my perception of you is of a typical drug courier or drug user, I'm going to be less apt to consider your qualifications for this position. To the extent that we've allowed our drug policy to create drug profiles, create user profiles, to have stereotyped drug users to be black, brown and otherwise, then we have done a disservice, not only in the area of drug enforcement but also in the area

of economic development, in the area of jobs, education, so on and so forth. Again, it need not be legalization or characterizing it as a health problem; it can be both.

Q. Don't you think that it's practically impossible to have law enforcement be fair as you've described it? The police are under pressure to make arrests and it's easier to make arrests of folks that operate in the streets rather than in the privacy of a mansion. It would take ten times more investigation to be able to arrest the person in the mansions compared with the person in the street. So there are natural tensions, it seems to me, that make it practically impossible, the way we're set up now, to have enforcement be fair, don't you think?

A. Yes sir, and that's exactly the point. It would be much easier if we didn't enforce the Fourth Amendment, if we allowed the police to go into a home and search whenever they wanted to without probable cause. The answer is not in the eradication of the Fourth Amendment, the answer is in increasing the police burden and also the prosecution burden. Let me give you an example. If we were to step up the police's ability to prosecute and investigate white collar crime, they would spend more time and effort in those investigations which are more difficult. To me, the emphasis has got to be on the policy side, not on the enforcement side of the law. So I think you're right.

Q. You talked a lot about perception, and one of the things I hoped you would address is the impact of media on the perception that all of the drug users are brown and black youth, brown and black males. Yesterday we heard a lot of statistics to the contrary and you never hear anything in the media about that particular perception. Just as when you hear about government aid and welfare, you don't ever hear about the true demographics of the recipients. How do you feel that impacts this inner city perception of who is actually using drugs and participating in drug crimes?

A. That's a good question. I'm actually doing a note right now on the characterization of the media as a Title 2 public accommodation. I believe that the media has a responsibility, just like the restaurants and the shops of the 1950's and 1960's, to provide an equal opportunity for persons to exchange ideas and so on and so forth. The media has done a disservice, particularly the print media, in showing only one side. I'm demonstrating that over the last 30 years, the teenage victims of violent crime have been reported in a disparate manner by the *Los Angeles Times*. The *Los Angeles Times* has access to the same number of statistics from the coroners office, but it chooses to portray deaths of black and brown in ways that perpetuate the myths and stereotypes we're talking about. And I do believe that if we were to hold the media accountable, in line with the First Amendment, but hold them also accountable as a business or a place of public accommodation, it would be different. And the same thing goes to reporting drug statistics. If it's not true, you shouldn't be able to print it.

To succeed, drug enforcement needs to become more self-consciously egalitarian. In plain English, it has to be fair.

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THE SOCIAL IMPACT OF DRUGS & THE WAR ON DRUGS: Growth and Political Power of the Correctional-Industrial Complex

Testimony of Dan Macallair

I am here today to discuss the impact and the growth of the corrections industry in California, the political implications of that growth, and how it relates to the war on drugs. I'd like to start with one experience I've had in the past year that dramatizes the impact of the drug war, and how it contributes to the overall expansion of what we are now calling the correctional-industrial complex. And it is real. Just as President Eisenhower recognized the dangers in 1960 of the expansion of the military-industrial complex, a similar danger is present today as we divert more and more resources to what we call the correctional-industrial complex or what some people call the punishment industry, law enforcement, or the correctional complex.

Just to give you an example: last year the *San Francisco Chronicle* ran an article about the drug crime wave in San Francisco, specifically, how San Francisco had become a beacon for drug sales, drug abusers, and drug sellers. The article basically interviewed two people: the head of the District Attorneys' Association Narcotics Enforcement Task Force and the Police Department's Director of Drug Enforcement.

Well, guess what they got? The conclusion of the experts that drug crime was rampant in San Francisco because our bail rates were too low, and we weren't incarcerating enough people. As a result, drug crime was out of control in San Francisco. I knew that this didn't sound right because I knew that crime was down in San Francisco—my agency had been tracking it pretty closely. So I thought there was something wrong here.

I went back and took out the statistics that are reported to the California Department of Justice each year by the San Francisco Police Department and I looked at the trends of the past ten years. What I found, not surprisingly, did not coincide with what was being reported. I was looking at the San Francisco Police Department's own statistics. Keep in mind who they interviewed. The head of the Drug Enforcement Taskforce on the San Francisco Police Department is obviously coming from a certain perspective.

When we think about the drug war and prison expansion in California—and I've been primarily focused on California though not exclusively—you have to think of it in terms of an industry. When I compared the years 1988 and 1997, I found that drug-related crimearrests in San Francisco and California are on the

decline—as they are in the rest of the country. Surprisingly, the rates have been declining faster in San Francisco than any other county in the state. When you go back to 1988 and look at who was being arrested, primarily narcotics (number one) and dangerous drugs. Marijuana was barely on the scale, with 565 arrests out of a total of ten thousand arrests in 1988.

Now let's go to 1997 when this "outbreak" was occurring. Where is the outbreak? These are the police department's own statistics. Not only was drug crime not rampant and out of control in San Francisco, it was on the decline. When I compared it to the rate of other counties, San Francisco was falling faster than the surrounding counties.

This article—it was a front-page article—was inflammatory, talking about the excesses of the drug trade in San Francisco and how permissive San Francisco was allowing this to get out of control. In the interviews and the articles, the points that were being made were that things were somehow out of control. There were virtually no evidence or statistics to support it, though that was what was reported.

Just as President Eisenhower recognized the dangers in 1960 of the expansion of the military-industrial complex, a similar danger is present today as we divert more and more resources to what we call the correctional-industrial complex.

I took this information and called the reporter and left a message saying, "I think you better go back and take a look at what you wrote and the information that you're getting. Because you're not doing your readers justice by not following up on statistics or at least trying to follow up from other sources than the sources that you used." I never heard back. I then called his supervisor and politely left the same message, saying I was calling with what I hope would be a fairly legiti-

mate point of view. I never heard back from the supervisor. However, I had also written a letter to the editor, and they printed it. The local director of NORML called to thank me for it, because I highlighted the fact that hard drug use was obviously going down, and since the narcotics police apparently needed something to do, they were arresting marijuana users.

With the Determinate Sentencing Act of 1976, California eliminated rehabilitation as a goal of imprisonment. At the time the law went into effect in 1978, we had 20,000 people in prison. We now have 160,000.

A few months later, a member of the San Francisco Board of Supervisors, a former member of the police commission seized on this issue and wanted to do something about "out-of-control" drug crime in San Francisco. Then the board holds a series of hearings to pressure the judges to raise bail rates for all drug and other offenders, under the premise that these crimes were disproportionately out of control in San Francisco relative to other countries because San Francisco was lenient and our bail rates were too low. This was the article filed shortly afterwards, "Bail Rates Raised Sharply for Many Crimes in San Francisco."

That's a small example of how policy was made in this jurisdiction on this issue with virtually no evidence to support the position. Yet because of one newspaper article and two interviews, crime control policy in San Francisco was altered. As a result of this, our jail population has now expanded and all on the basis of a couple of interviews with vested interests. I wanted to start with that example, because it is amazing how much policy is made with very little information. Yet there is a potent myth that crime is out of control, specifically drug crime, and the only way we can get a handle on it is through tougher and tougher sanctions and more incarceration.

I want to talk about some of our research and other research as well, about how we got here in California, and about what has contributed to the current trends. For those of you who aren't aware, since the 1980s California has launched the largest prison expansion in the history of the world. From 1852 to 1984, California built 12 prisons. Since 1984, California has built 21 prisons. During that same time we also built one university, despite the fact that universities are also becoming overcrowded. How does it happen? What has contributed to this?

During the 1980s, there were changes in the laws in California that led to a more punitive approach to sentencing. With the Determinate Sentencing Act of 1976, California eliminated rehabilitation as a goal of imprisonment. At the time the law went into effect in 1978, we had 20,000 people in prison. We now have 160,000. When the prison expansion began in 1984, there were approximately 12,000 prison guards and prison expenditures accounted for about three percent of the state budget. There are now 28,000 prison guards in the state of California.

Right now the most powerful political action committee in the state of California is the California Correctional Peace Officers Association (CCPOA)—the prison guards' union. In this last election alone, they poured over two million dollars into Grey Davis, a Democrat. They poured a larger amount into the gubernatorial campaign of Gray Davis than Pete Wilson's four years earlier. At that time, it was called the largest independent campaign expenditure in state history. Beginning in the late 1980s and early 1990s, the prison guards' union really came into its own as a potent political force in Sacramento. That has resulted in a number of things, primarily tougher sentencing laws. The union pours a lot of money into political campaigns, and one of the things that's not always recognized—the victims rights' movement in California.

No one is in favor of violent crime; everyone feels for the person who experiences a horrible tragedy, violent crime or is victimized. The victims rights' movement is funded, at the state level, almost solely by the prison guards' union. If you look at the major voices in Sacramento, the Doris Tate Crime Victims Union is funded entirely by the prison guards' union (or at least they were two years ago). It is based in the Prison Guard Union, the CCPOA, headquarters in Sacramento. It shares the same lobbyist. The Crime Victims' United Pact is funded solely by the prison guards' union. Mothers of Murdered Children is funded by the prison guards' union. The head of the prison guards' union, Don Novey, has said, "Any group of victims who want to get together and organize, we will fund you."

They have developed a very tight relationship, a symbiotic relationship, between the victim's movement in California and the prison guards' union. Anytime you go to a hearing in Sacramento where incarceration policies are being discussed, you will find that the positions taken by the Doris Tate Crime Victims' Union are the same positions taken by the California prison guards' union. I've seen it over and over. I've been to my share of hearings in Sacramento. It is an extremely powerful political force.

I want to show you some of the breakdowns of the campaign contributions. This is some of the analysis we did for the 1996 elections in California. We looked at July to November, and what we found is that during that time period, the CCPOA contributed almost one million dollars, just during that time period. Where did it go? Sixty percent went to the Republican party, 25 percent went to Democrats, eight percent went to propositions, events and miscellaneous, five percent went to crime victims' organizations, and other law enforcement agents received about one percent. But if you look, a huge chunk clearly went in favor of the Republican party, which had been the "tough on crime" party up until a few years ago. Right now the politics in Sacramento is that the Republicans and Democrats are scrambling, trying to outdo each other on the "tough on crime" issue. Gray Davis has rejected the parole of five people who were unanimously approved by the old Wilson parole board and he said that "no lifers are going to be paroled while I'm governor."

You can't overestimate the political might of the correctional industry in California. This political power has been transferred into harsher and harsher legislation, the "three strikes" law. The campaign for the three strikes law was funded by three primary bodies, Michael Huffington for senator, the National Rifle Association (NRA), and the prison guards' union. The three strikes law is considered the most draconian law ever passed in recent years by any state. It's going to force the state to double its current expenditures on correction. Who gets sentenced under three strikes? Three strikes is mislabeled. It's actually a two strike law. Of the 40,000 people sentenced under three strikes, 35,000 are sentenced after two strikes. The way it works is, if you commit one violent or serious felony from age 16 on up, that's one strike. If you commit a second felony—any felony—you get double the sentence that you otherwise would have received. Drug possession is the most frequently sentenced crime under the three strikes law.

Right now, corrections account for nine percent of the budget, up from three percent in 1984. If the current trend continues, according to a RAND study and projections by the legislative analyst's office, the percentage of the state budget going to corrections will exceed 18 percent. Much of the budget—84 percent—is tied up in other things. It's not all discretionary. So they're talking about a very small percentage of the state budget that is then left over for everything else. Who has to compete for that? Higher education has taken the biggest hit from the California prison expansion.

Questions From Commissioners

Q: You said the RAND corporation came out with an 18 percent figure. Over what time period was that?

A: The projections appeared false at first, because the prison population has not grown as fast, but no one really knew. What they're saying is that it has increased at a slower pace. The reality is it will increase and the pace will start to become more rapid as people start serving sentences that are longer than the sentences they otherwise would have served. Ultimately, the projections will come true.

Q: I was out speaking about five years ago, giving these same statistics and I said that in 1984, we had 13 state prisons and that since then we had built an additional 15. After my talk, a man introduced himself and said, "You may not be aware of this, but I've heard these statistics before, and I'm an accountant, so I penciled it out. I found that if prisons in California grow in the future at the same rate as we have in the last twenty years, literally by the year 2020, everybody in the state of California will either be in prison or running one."

> *[R]ight now the most powerful political action committee in the state of California is the California Correctional Peace Officers Association (CCPOA)—the prison guards' union.*

A: Right! You have to understand that the prison industry is the successor to the 19th century factory system. If you drive up I-5 from the Mexican border to the Oregon border, you are never more than an hour away from a prison in California. Where are they located? They're in the central valley in these small towns where they are the sole source of employment to the population. It's not like the old days when people used to say, "Not in my backyard." Now you have communities throughout the country lobbying to have prisons built in their communities because the days of producing textiles and cars are over. This is blue-collar employment so you have communities that are fighting for them. If you look at these communities, up and down I-5, these are places that would not have jobs available were it not for the prison.

Who has born the greatest weight of this prison expansion? Contrary to popular belief, the prison expansion in California has not come at the expense of the violent offenders. Much of the expansion in California has been the rampant number of drug offenders sentenced to state prisons in California. The percentage of violent

offenders in prison has fallen over the last twenty years. In 1980, 60 percent of the California prison population were there for violent offenses. It's now 42 percent. At the same time in 1980, eight percent of the prison population were there for some drug-related offense. It's now 28 percent. This is the only area where you've seen that rapid rise. Property offenses were 25 percent in 1980 and 24 percent today. This is where the dramatic changes have occurred. This is going to continue as long as the industry seeks ways to not only continue, but expand. That's the nature of industry. This is not a plan that anyone sits down and plots out. It just happens, because once you're able to rationalize that what you're doing is right and good, you can justify anything. If, for example, as we saw in San Francisco, the rate of drug consumption in one area goes down among the more dangerous drugs, you simply shift your resources to the less dangerous drugs under the belief that we licked it with the more dangerous drugs and now we'll go after the less dangerous, less serious offenders. Someday we'll eliminate crime, and we're going to do it because we'll have more law enforcement and more prisons; that's the mentality that drives it right now. I'm not talking about the average prison guard or person in the street, they don't see it that way. It's the leadership, for example, of the CCPOA and the state sheriff's departments. We're starting to see them now in Sacramento arguing and advocating on behalf of these tougher sentencing laws. The jails have experienced tremendous growth since the passage of "three strikes." Now you have the sheriff's associations coming into California and lobbying for the preservation of three strikes and all other kinds of sentencing enhancements.

Dan Macallair is associate director of the Center on Juvenile and Criminal Justice (CJCJ), a private, non-profit organization whose mission is to reduce institutionalization as a solution to social problems. CJCJ provides technical assistance to states and counties, case management, and research and publications. Macallair has served as an advisor to the Little Hoover Commission's Juvenile Justice Advisory Board and the San Francisco Mayor's Juvenile Justice Task Force. He currently serves as President of the Board of Directors of Coleman Advocates for Children and Youth and serves on the faculty of the Criminal Justice Program at San Francisco State University.

THE SOCIAL IMPACT OF DRUGS & THE WAR ON DRUGS: Public Health vs. Criminalization Policies

Testimony of Ricky Bluthenthal

Thank you for inviting me to speak before this commission. By way of orientation, most of my research has been on injection drug use. So I have a lot of specific recommendations about that and I'll share those with you. But I want to start with the role marijuana plays in forming policies about drug use, because I think it is a large part of the problem.

Having heard a day and a half of testimony, there probably aren't too many people in the room left who believe that current strategies are effective. And in fact, individuals on both the left and right are pretty vocal about their opposition. For instance, William Bennett opposes the way the war on drugs is being conducted because it pays insufficient attention to the moral foundations of drug use. On the other hand, the costs and consequences of the war on drugs on minority communities has been particularly devastating. I agree with Professor Ferguson who suggested that the war on drugs has become its own independent variable for racial inequality in the United States, given the distribution of arrests and the impact of imprisonment and incarceration on people's subsequent capacities to form families and support those families.

What I'd like to offer today is a public health approach. One of the advantages of a public health approach is that it isn't an ideological one. You can take a somber view of the consequences and harms of particular activities and then ask, "What do we do? Is the medicine worse than the disease?"

A good place to start is to think a little bit about alcohol. As you all know, alcohol is legal in this society, and I'm sure most of you drink. You probably enjoy drinking and it probably doesn't result in any sort of significant harm to you. But for many other people, it is a big problem. Alcoholism is rampant in our society. Some 40,000 people a year die as a consequence of alcohol-related traffic accidents. Folks who have abused alcohol for a long time tend to have problematic family lives, their ability to parent is impaired, and finally, there are serious illnesses. Many liver transplants are owed to alcohol abuse.

So the question is: Where does marijuana fit on this continuum of harm to self/harm to others? Lots of people smoke marijuana. By now, if the sort of serious consequences that we know to be associated with alcohol were associated with marijuana use, it would be readily apparent to all of us. By my judgment, you just

don't see that. I attended, as an undergraduate, UC Santa Cruz, which, unfortunately, is often associated with lots of partying and drug use, and there certainly was some of that going on. Most of those people turned out okay; they're lawyers and doctors involved in their communities and their families. The consequences that you would expect from problematic substance abuse such as failure to graduate, inability to develop relationships, just haven't happened. In the broader society, that holds as well. Most illicit substance users are marijuana smokers. So you don't have a great harm being produced, at least to the individuals. The other thing, of course, is that marijuana has some medicinal properties—glaucoma, cancer patients receiving chemotherapy, and AIDS patients suffering from lack of appetite—there's enough personal testimony and now some pretty well designed studies being conducted at UC San Francisco to substantiate the medicinal properties of smoked marijuana.

What I'd like to offer today is a public health approach....You can take a somber view of the consequences and harms of particular activities and then ask, "What do we do? Is the medicine worse than the disease?"

The next thing is that the distribution of marijuana isn't all that problematic, either. While there are many settings where marijuana is also available alongside heroin and crack, certainly the newspapers haven't told the stories of marijuana-selling gangs involved in street turf fights over particular corners or rampaging youth toking up and going out, beating their parents and putting graffiti on walls. Most of the war on drugs efforts are spent on incarcerating largely inner-city minority male populations involved in the street sales of crack and heroin. That effort isn't doing anything to reduce the availability of marijuana. In 1975, 87 percent of youth reported marijuana as being fairly easy to obtain; in 1998,

that percentage was 89 percent. So it's just as available as it ever was. By saying that, I don't want to suggest that we want to permit general sales and marijuana use as we do alcohol. I would recommend a different approach.

Since marijuana use is with us, folks arrested for having small quantities of marijuana should probably be treated in the same way that I get treated when I illegally park or when someone has a speeding ticket. Of course, marijuana, like any other substance, could have more graduated and severe penalties with possession of drugs in school settings.

[D]rug users are shut off from the rest of society. As with any group, once people are shut off, bad things multiply.

In the grand scheme of things, marijuana is probably less dangerous to us than alcohol. If we remove marijuana as a pillar in the debate over drug policy, I think we have the opportunity to get down to the problem of heroin and cocaine use. There are about two to three million people in the U.S., according to government estimates, that use heroin and cocaine on a regular basis. For those folks, their use is highly problematic. In the studies on which I've worked at University of California at San Francisco, we've had contact with around 14,000 heroin and cocaine injectors in the San Francisco Bay area over the last decade.

As you don't need me to tell you, drug use causes problems for these people, and many of them are interested in alternatives. But drug treatment often isn't available to these individuals. As a consequence of their drug use, they've been stigmatized by family and friends. Their drug use can place their family and friends at risk of losing public housing or federal assistance. There are laws in public housing: if people are known to be using drugs in your home, you can get kicked out or evicted or to be selling drugs. So drug users are shut off from the rest of society. As with any group, once people are shut off, bad things multiply.

The U.S. stands alone as one of the few industrialized countries to have a serious HIV epidemic among injection drug users. Hepatitis B is rampant among these populations. Hepatitis C, which is the new HIV in some respects, has already affected somewhere around two to three million people in the United States. In future years, we're going to hear about the medical costs associated with treating this disease which continue to increase. Tuberculosis and multi-drug-resistant tuberculosis developed in injection drug-using communities in the United States.

What can we do? First, expand drug treatment. If you're addicted to heroin or cocaine, you're in this strange class of people who have an ailment for which getting treatment is intentionally made difficult. The routine admissions, for instance, to a methadone program in the State of California or elsewhere is that you have to appear at the drug treatment facility early in the morning with symptoms of dope sickness or withdrawal. Withdrawal symptoms are like having a really bad flu: you may have body pains and shakes. You may also be suffering from gonorrhea. You then get a medical examination, you sit around for a couple of hours, and then finally, at some point, three, four, or five hours later, you'll receive a dose of methadone which will relieve those withdrawal symptoms. If any of us were in a car accident, we hope that if we're sent to the emergency room, we'd get treated in a timely fashion. But we intentionally make access to drug treatment, especially methadone, difficult for individuals.

Second, we don't have enough drug treatment capacity. Michael Massing in his book *The Fix* points out that in the early 1970s, we spent about 65 percent to 75 percent of our drug control budget providing drug treatment. Those numbers are now flipped. We now spend about 25 to 35 percent on drug treatment. As a consequence, many drug users who want to get into drug treatment can't because the capacity simply isn't there. And in the studies that I've conducted in San Francisco, we found that, depending on how you measure it, anywhere from around 25 to 60 percent of drug users would take a drug treatment slot if it were available the next day. There's a huge demand for this medical service. Many of the problems associated with drug use are a consequence of the individuals who are chronically addicted to heroin and cocaine, yet the remedy for those problems is not made available.

Some colleagues of mine at RAND have demonstrated, I think quite ably, that providing treatment is much more cost effective than not providing treatment or alternatives to drug use.

[Interruption by Commissioner: A dollar spent on drug treatment produces seven times more value than a dollar spent on incarceration, eleven times more value than a dollar spent on interdiction at the border, and something like 22 times more value than attempted eradication in Bolivia or wherever else. So if you care about achieving results with tax dollars, drug treatment is by far the best investment.]

Exactly. We should also consider greater varieties of drug treatment and other ways of normalizing drug treatment. It used to be that you could get prescribed methadone for a short period of time. The original methadone prescription was done on an outpatient basis. We should contemplate allowing less problematic drug users to move off the highly regimented, structured environment of methadone programs and allow them to get it from their primary physician. That would be less disruptive to their lives, and they could renew their prescription as needed the next month. Treating them as outpatients would also allow them to earn more money, etc.

By expanding drug treatment and reducing the number of drug users, you actually prevent new drug injectors. In low income communities, most people get introduced to injection drug use from someone who's already an injection drug user. So it stands to reason that if you reduce the number of injection drug users roaming around communities, you'll probably also reduce the number of people who are likely to be brought into injection drug use. Injection drug use doesn't happen from dealers offering them to folks they don't know. It usually happens from a relationship, sometimes a central one, that progresses to this next point.

There are a whole series of other problems associated with injection drug use having to do with infectious diseases. We need more needle exchange programs; we need street outreach to chronic long term drug users to give materials that protect them from HIV and other infections diseases, and we need to provide condoms to protect the rest of the population and their sexual partners from transmission of diseases which have a sexual route.

Having interacted with folks who are involved in the drug life, it's been my experience that many injection drug users don't have the opportunity to consider a different lifestyle for themselves. They don't have the opportunity to access new resources that they haven't typically had, because the drug use is such an overwhelming identity both legally and socially.

Another big problem is overdoses. In San Francisco, overdose is a huge problem. Overdoses happen for a variety of reasons, but one of those reasons is because if you report an overdose to medical authorities, you can get arrested. A third recommendation we should consider is not arresting people for reporting an overdose. The strongest variable for predicting overdose is having been in prison. People who have been incarcerated start using drugs after being released. Other high risk populations are people who have been on treatment and people who are alone. There are plenty of cases where someone begins to overdose and the people with them panic; they don't want to get arrested, so they just leave the person in medical crisis.

A fourth recommendation would be to distribute Narcan to active injection drug users. There are going to be some attempts in the Bay Area to do this. Narcan is a anti-heroin/opiate drug that can bring people back from a trip. In fact, a doctor at the emergency room of San Francisco General Hospital said that when people come in with overdoses, he first just whispers Narcan and in half of the cases, people wake up.

Fifth, we should consider changing drug paraphernalia laws, at least with regard to syringes. A lot of the spread of HIV is due to the fact that injection drug users aren't willing to carry their own equipment with them because they can get arrested. Recently published studies show that syringe sharing is clearly associated with ongoing risk to injection drug users. Reforming drug paraphernalia laws to allow individuals to carry syringes is, therefore, warranted.

The U.S. stands alone as one of the few industrialized countries to have a serious HIV epidemic among injection drug users.

There are some interesting experiments going on in terms of law enforcement. I would endorse drug courts. I'd endorse drug treatment for people who are in prison and for parolees, but, of course, I'd mostly endorse treatment for people who aren't incarcerated. We should get ahead of the problem rather than dealing with it after the fact.

Before I conclude, I would like to talk about a broader issue. A professor of drug use in Amsterdam did an interesting study—more of a think piece—about why crack became such a big deal in the United States. It really isn't that big of a deal anywhere else. He considered the introduction of crack in Amsterdam and compared it to what happened in New York. His conclusion was that because The Netherlands has an adequate social welfare system where people are regularly provided with housing and food, the appeal of crack cocaine wasn't as great. Crack never really reached any epidemic proportions.

In the United States, on the other hand, the poor are really left to their own devices. We don't do a very good job of revitalizing inner city communities, regardless of who happens to be in office, be they Democrats or Republicans—at least in the 20 years that I've been following this issue. I think that has a lot to do with the extent of the serious drug problems that we're facing.

Most of the reasons why one wouldn't become addicted to a drug have to do with what you have to lose. For instance, in my case, I have a lot to lose. I have a wife, I have a house, I have a job. Chronic drug use would be a real problem for me. But if you don't have a stable family, if you don't have a good education, if you don't have good job prospects, and this stuff is out in the environment and it's going to make you feel better about yourself, you're probably going to use it. I think we should also consider for a moment the tremendous use of sleeping pills and valiums and other sorts of mood altering drugs in this society among middle class groups and upper middle class groups. We may be the society with the largest per capita of pill poppers in the history of mankind.

I'd endorse drug treatment for people who are in prison and for parolees, but, of course, I'd mostly endorse treatment for people who aren't incarcerated. We should get ahead of the problem rather than dealing with it after the fact.

An important component to understanding and dealing with drug use problems has to be getting at some of these fundamental economic and social structural issues that are going on in poor communities. We have to have a game plan for allowing people with minimum skills to earn a living wage. More importantly, we have to have a plan for their children to have reasonable prospects of attending college and attaining the middle class dream that we all want for ourselves and certainly for our children.

In conclusion, let me summarize some alternatives to the war on drugs. First, I think it's important to decouple marijuana use from the way we deal with issues of heroin and cocaine use. Second, we need to have a central approach to drug addiction. When people get sick, we give them more resources, not less; we put them in environments where there's an opportunity for them to heal, not in situations where there isn't. Third, we have to address the fundamental issues. It's not an accident, and as a sociologist I can tell you, that these problems more directly impact African Americans and Latinos who live in poor neighborhoods. I assure you that the problem is not a function of their culture or orientation or that they like to do drugs more than other groups. That's simply not the case.

Questions From Commissioners

Q: You are in communication with a number of injecting drug users in one fashion or another, as I understand it. Have you talked to them as to why they got involved in this to begin with? I know despair and hopelessness is a part of it, but were they given a free sample, is that how they first used drugs? The idea to me of injecting myself with anything is certainly not appealing. I would do it if I were diabetic, but how do people really get started using injecting drugs, do you know?

A: It's a question I've looked at, and I've asked people about. I think there are two or three different reasons. One is Vietnam. A lot of the people out there injecting heroin, speedballs, and cocaine are Vietnam Vets. I didn't go through that, thankfully, but war is a bad thing and a lot of the individuals that came back were damaged by it. The largest treatment system in the United States is Veteran's Affairs; drug treatment is a huge portion of their work.

Another reason is family trauma, at least for runaways and kids who are involved with drugs. A recent public television documentary on black tar heroin, as well as my own research and that of my colleagues at the University of California at San Francisco, have shown that many of these kids using drugs have been subjected to incest, physical abuse and neglect. They're damaged and in a great deal of pain. We don't have good resources to help children work through their pain.

I think a third source is a sort of "why not?" If you're in an environment where a lot of folks are using the drug, and you happen to end up in a social network where all your friends are doing it, you might just start. I've seen it happen to 30 to 35-year-olds, who are well past the age when people usually start. My take on it is that they just don't have a reason not to. There's not the other things going on in their lives that would make them choose a different route.

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SOCIAL IMPACT OF DRUGS & THE WAR ON DRUGS: Workable Alternatives

Testimony of Mike Gray

You've already heard more than enough to make up your minds on this subject, so I just want to tell you a couple of quick stories. During the six years that I was doing research, one of the most interesting sagas that I came across was in '94. I went to Liverpool, touring Europe to see the various approaches to drug policy they were taking in Holland, France and Germany. In England, I went to Liverpool to see Dr. John Marks, a clinical psychiatrist who was running a small clinic for some 450 addicts in a suburb of Liverpool. At the clinics, I was privileged to sit in with a group of eight heroin shooters who had come for their weekly prescription.

These eight kids were in their twenties, indistinguishable from any other eight people that you'd find on the streets of Liverpool. They all had jobs and homes and families and a serious heroin addiction. They assembled in this little group for an hour. It wasn't a counseling session, it was just basically a conversation with doctors to make sure that they were in good shape physically. The doctors didn't interrogate them or anything else. At the end of this, of course, they got their prescriptions and went down to the corner to have them filled. They came in and did this on a weekly basis.

One of the most interesting of the eight, to me, was a young women I call Maureen, although that's not actually her name. She could have been a middle class schoolteacher in any high school in the country, a very well dressed, alert young woman. I interviewed her after this session and she told me how she'd gotten in. She was a middle class woman from the Manchester area who had married a rich kid. He got her into a serious heroin habit, gave her three children and then met a younger woman and ran off with her, leaving Maureen with the three children and a serious heroin addiction. She had no money; the money had all been spent on drugs. She survived over the next five years with these children in tow, moving from one bed and breakfast to another, inches ahead of the authorities, supporting herself with prostitution and shoplifting.

One day she was aware of the fact that the authorities were closing in on her and that she was in serious danger of losing these children, who were the one thing left in her life. So she talked to a general practitioner in Liverpool and he said, "Your problem is you're a heroin addict. You should go to Chapel Street Clinic and see Dr. John Marks. He'll take care of you." So, she goes to Dr. Marks who gives her a thorough physical examination and tells her to come back one week later and he'll take care of her problem. She comes back for

the follow up session, and he has checked all her credentials to make sure she is indeed a heroin addict of long-standing and seriously has tried to kick many times. He signs her up for his program and says, "Here, take this prescription down to the corner and the chemist there, he'll fill it. "

[T]he American Embassy was insisting on shutting down this clinic...because it was sending out all the wrong messages. It was sending the message that people on heroin can have functional jobs, pay taxes, and be normal citizens.

She looks at this piece of paper, as you can imagine, with a certain amount of disbelief. She goes down to the corner and she hands it to the pharmacist, who, without a word, takes it and returns with a little cardboard tub with a metal lid containing one week's supply of pharmaceutically pure heroin and a box of clean needles. As she's looking at this in disbelief, she happens to catch a glimpse of herself in the mirror. For the first time in ten years, she realizes that she doesn't have to worry about whether or not the guy is going to be there, whether or not the cops are going to get there first, whether or not this shit's going to be any good, whether or not it's going to be adulterated with something deadly. She won't have to vamp with her children and promise them ice cream that she has no intention of ever getting them in order to keep them sitting still while she's in there waiting for the dealer to show up. All of that incredible intensity of mental effort that has governed her life for the past ten years begins winding down. For a brief instant, there is enough brain space to think about something other than the next fix.

At that moment she catches a glimpse of herself in the glass and realizes that it's the first time she's actually

seen herself in years. And she says, "Oh my God." Then she turns around and looks at these three kids behind her and says, "What have I done?" In that instant, all the middle class values that this woman had been raised with came flooding back to her. She had mental room enough to think about something other than the next fix. People think of junkies as indolent idlers, but if you're in Manhattan and you see somebody hurrying down 125th street, that's a junkie. All purposeful, heading somewhere, a man on a mission. These people devote 100 percent of their energy to this problem.

And now Maureen had come under the care of Dr. John Marks and she had, at that time, been on this program for two and a half years. She had completely stabilized her dose, was not increasing in tolerance. She took the drug only to feel normal. She didn't get high, and she was thinking about quitting. She said, "I can't go to France on holiday, I'm stuck here in Liverpool, I don't dare leave from this clinic, I'm anchored to it, I get nothing from the drug, so I'm seriously thinking of quitting because I'm planning to go back to college next fall. I want to be done with this heroin habit, but I know that I have the safety that if I begin to detox and I can't make it, if it turns out that it's too painful, I know Dr. John Marks is going to allow me to come back to where I was. It's not a do or die, and this is an opportunity to try detox." And she was prepared for that.

[T]he United States reached into an effective, functioning treatment facility and squashed it because it didn't match our ideas of what we think is the appropriate approach.

Unfortunately, Ed Bradley of "60 Minutes" also became aware of this and he did a piece and the American Embassy went through the roof. The U.S. drug officials began raining down disaster. John Marks was advised by friends inside the British Home Office that the American Embassy was insisting on shutting down this clinic and that they were applying every manner of conceivable pressure to the Home Office to see that this was accomplished because it was sending out all the wrong messages. It was sending the message that people on heroin can have functional jobs, pay taxes, and be normal citizens and it also debased the concept of the necessity for abstinence as the only solution for this problem.

As a consequence, in 1996, 18 months after I was at the clinic, the British government withdrew the support for the Chapel Street Clinic. They simply cancelled the contract and they turned this over to a faith-based Christian fundamentalist group that had no knowledge of drugs, detox, or anything else, but were willing to follow the American model of methadone treatment—21 days and out.

Bear in mind, the success of this program was emphasized by the local suburban police; the crime rate had dropped dramatically because of this program. There were no homeless among this addict population, there were no cases of AIDS in this entire 450 addict cohort. Not a single case of AIDS, even though Liverpool is a port city. It was clear that this had been an enormous success. There were no overdose deaths, yet in the 12 months following the time when they turned it over to this Christian faith-based organization, they had 25 heroin addicts that had died and practically all the other 450 were back on the streets. The pushers who had been totally unknown in this area immediately returned to serve this new clientele.

And what of Maureen, the young girl with the three children who had a home and a family and had finally put her children back into school? When Marks last saw her, she was on the streets again, back into prostitution. Most of her friends were in prison; she was desperate to get back into any program at all.

This is an example of how the United States reached into an effective, functioning treatment facility and squashed it because it didn't match our ideas of what we think is the appropriate approach.

I wanted to mention one other thing: the Swiss heroin maintenance experiments. We've heard of needle park, and the example that the U.S. government always puts forth is that the Swiss tried legalization in needle park and it didn't work, it was a disaster. That is not the case. The situation in Platzspitz Park is what they're talking about. This was in the early 1990s and the Swiss had some 750 serious addicts in Zurich and they were in everybody's face. They were at the train station, they were bumming money, they were hanging around, they were shooting up in public and the local authorities said, "Here's the deal. You guys go over to this park by the river Platzspitz, you stay in there with your dealers and don't come out, and you can do whatever you want and we won't come in; it's free territory."

Well, that was a nice idea and it solved the problem for about two weeks, but by that time, every junkie in Europe had heard about the place. They had something like 2,500 junkies a week later and pretty soon they had almost 20,000. They were flooding in from all over the place; it was just a nightmare. We could have accomplished the same thing during alcohol prohibition by declaring Lafayette Park an alcohol zone and

all the alcoholics would have showed up. It was not an experiment in legalization, as drug czar McCaffrey would put it, rather an experiment in street cleaning which failed.

So they then decided to take a much more scientific approach. They offered 1,000 serious addicts an option of methadone or heroin. These addicts were people who had to qualify as being serious junkies for two years or more and who had tried to quit at least three times. Nobody picked methadone. They all wanted heroin. Why? I think one reason is because methadone is really a convenience for the administration. It is synthetic heroin. You can get high from it. There are people who don't use heroin, but use methadone illegally. So methadone is just simply synthetic heroin, but like all synthetics, it has terrible side effects that the natural product does not have and it's much tougher to kick. With heroin, physically, you can get through in about three days, whereas with methadone, some people say it takes a month. The Swiss then proceeded to give these people heroin. This was supervised by the World Health Organization. They did an independent audit of this study and found that the deaths due to overdoses among this cohort of 1,000 had dropped by half, crime among the group dropped by 60 percent, half of the unemployed found jobs, one-third of the people who were originally on welfare became self-supporting. Homelessness was eliminated completely and the health of the entire group improved dramatically.

The most significant thing for those of us who are concerned with drug policy and who are not concerned with getting our next fix is that 83 of the patients in this group quit using. Not under force, but simply because they were in an environment that allowed that to happen. And that, incidentally folks, is just about the same cure rate that you get from any other treatment program. In other words, as Dr. John Marks said when I interviewed him, you get about five percent a year who will roll out. And that was true at the clinic in Liverpool. Five percent a year spontaneously decided to quit. That's what you get: it doesn't make any difference if you give it to them or if you chase them down the street with whips and chains. You get five percent a year that roll out. Now that may not sound like a lot, but you start thinking about it over a period of time, five percent a year is a fairly sizeable chunk. If you're constantly reducing the number of users. But our problem is we're constantly increasing the number of users with our draconian policies.

The last thing I wanted to tell you is a story I just finished for *Rolling Stone*. I was in Plano, Texas ,and a lawyer came up to me and said, "I've got a kid that I'm representing who was introduced to heroin and became an addict." His parents got him into rehab and then, of course, he relapsed because, as any of you who have ever tried to quit smoking cigarettes knows, addiction is a relapsing condition. You usually try to quit three, four, five times before you actually quit. And certainly that's true of heroin, which is almost as addictive as tobacco.

And so the kid's parents were, on the second pass, advised to give him tough love. They cut him off without a dime but didn't cure his addiction, so he's got two choices, steal or deal. Well, he was too honest to steal, so he began dealing, and one of the kids that he dealt to died. He was one of the 20 kids who died over an 18 month period in Plano from heroin overdoses. So this kid is now looking at a mandatory minimum of 20 years to life because he was connected in the chain.

The Swiss then proceeded to give these people heroin…[D]eaths due to overdoses among this cohort of 1,000 had dropped by half, crime among the group dropped by 60 percent, half of the unemployed found jobs, one-third of the people who were originally on welfare became self-supporting

It became such a famous case that the federal government came in and dropped this H-bomb on Plano and rounded up all these kids. Because of an obscure enhancement to the conspiracy law passed by Clinton, it's now possible, if a sale leads to a death, that everybody in the chain can be charged with a mandatory minimum of 20 years to life. So in Plano you've got two classes of kids—the kids who died and the ones who survived and are now off to jail.

I interviewed the chief of police of Plano, very nice guy, ignorant as sin to all the realities of the drug war. I told him none of these kids needed to die. The kids drove one of their friends who had died around for a day and a half until his body was stiff as a board and then they left him in a church parking lot. They couldn't think of anything else to do and they were terrified of taking him to the hospital. In almost all of these cases, that was the situation. A kid was clearly in trouble and they tried to wake him up and do everything short of what they should have done which was take him to a hospital. When they finally got around to doing it, it was too late. Although not always: the head doctor of the emergency room managed to save 140 kids who overdosed. This is a town of 200,000. And so you lost 20 and saved 140 in an 18 month period, I believe.

I said to the chief, "Why don't you simply give everybody a free pass, make an announcement, if you bring

somebody in who's in respiratory arrest, no questions asked?" He said, "That would send the wrong message."

Well, the message they would rather send is that we don't care about lives or children or anything else, we're only interested in proving things.

In the situation in Adelaide, Australia, by contrast, they were confronted with exactly the same situation and they had little refrigerator magnets. They said, "What to do if your mate drops"—that's their term for overdosing—and they put out posters, "Don't do it alone." They tried to minimize the harm that they knew was happening because they've got the same situation that we've got—an incredible explosion of youth using heroin. It's a nightmare.

In 1980, the average heroin user in Holland and the United States was 25 years old. Today, the average age of a heroin user in Holland is 36. That's what we're looking for. An aging heroin population indicates that younger people are not coming in. In the U.S., it has dropped from 25 to 19. So we now have 19 year old heroin users. Barry McCaffrey tells us that the biggest single bump in heroin users in this country, in most recent numbers, is among 8th graders. This cannot be considered a successful policy.

So in Plano you've got two classes of kids—the kids who died and the ones who survived and are now off to jail.

Questions From Commissioners

Q: What evidence do you have, if any, that the United States government pressured the British Home Office about the clinic? I've heard this everywhere.

A: It's only anecdotal, Judge. John Marks gave me the names of the people in the Home Office who had advised him that the U.S. was putting this pressure on the British. I attempted to talk to two of them, but I wasn't able to connect with them directly. I don't have absolute proof, but the circumstantial evidence certainly followed as the night follows the day. Each of these things led directly to the next step. So, circumstantially, it appears that we are responsible for this. There was no other outcry against this clinic. It had been enormously successful. The local police appreciated the fact that this clinic was functioning and were very sorry to see it go.

Q: Mike, I had heard that the local merchants gathered together and donated money to support it because shoplifting had gone down seven fold in the neighborhood surrounding the clinic. Had you heard that too?

A: Very good point, I had heard that.

Mike Gray is an award-winning screenwriter, author, journalist, producer and documentarian whose work includes the films *The China Syndrome* (which he wrote), *American Revolution II*. and *The Murder of Fred Hampton*. His books include co-authorship of *The Warning*, a definitive account of the nuclear accident at Three Mile Island; *Angle of Attack*, a history of the Apollo space program; and most recently *Drug Crazy: How We Got Into This Mess and How We Can Get Out*, based on six years of research and writing about drug policy.