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CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

National Center for
HIV, STD, and TB Prevention

NCHSTP

Office of the Director
Office of Communications
Facsimile Cover Sheet

Date: 9/15/99 Pages: 32 (including cover)

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1999 Atlanta, Georgia August 29 - September 1

HIV Prevention Now More Than Ever

FOR RELEASE:
August 30, 1999
All Data are Embargoed Until Time of Individual Presentations

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- PRESS BRIEFING MONDAY, AUG. 30, 3:00 PM EDT -

HIV CONTINUES TO EXACT TOLL ON AFRICAN AMERICANS

- New Epidemiological Data Show Growing Racial Gap in AIDS Epidemic -

- In Response to Changes in the Epidemic, CDC Continues to Expand Funding for African-American Programs --

Atlanta, GA - AIDS death rates in 1998 remained nearly 10 times higher among African Americans than among whites. Similarly, the rate of AIDS incidence rates is almost 10 times higher among African Americans than whites. National AIDS incidence and mortality data for 1998 were released earlier today by the Centers for Disease Control and Prevention (CDC) in the opening plenary session at the National HIV Prevention Conference. ***[See attached table and forthcoming CDC press release for data to be discussed. Helene Gayle, Opening Plenary, Monday, August 30, 8:30 a.m.]***

Race and ethnicity in the United States are not risk factors for HIV infection, but correlate with other more fundamental determinants of health status such as poverty, access to quality health care, health care-seeking behavior, illicit drug use, and living in

- more -

Conference Co-sponsors: AIDAtlanta ● Academy for Educational Development ● American Social Health Association (ASHA) ● Association of Public Health Laboratories ● Centers for Disease Control and Prevention (CDC) ● CDC Foundation ● Council of State and Territorial Epidemiologists (CSTE) ● Health Care Financing Administration ● Health Resources and Services Administration (HRSA) ● Indian Health Service (IHS) ● National Alliance of State and Territorial AIDS Directors (NASTAD) ● National Association of People with AIDS (NAPWA) ● National Council of STD Directors (NCSD) ● National Minority AIDS Council (NMAC) ● Office on AIDS Research (OAR)/National Institutes of Health (NIH) ● Office on Women's Health/Department of Health and Human Services ● Rollins School of Public Health/Emory University ● Substance Abuse and Mental Health Services Administration (SAMHSA)

communities with high prevalence of STDs. Acknowledging the disparity in HIV and STD rates by race or ethnicity is one of the first steps in empowering affected communities to organize and focus on this problem.

"In communities across the nation, young African Americans are being infected at alarming rates," said Cornelius Baker, moderator of the press briefing and the Executive Director of the National Association of People with AIDS, one of the conference co-sponsors. "The research presented here today clearly demonstrates the terrible impact of AIDS on our community and the need for continued aggressive HIV prevention efforts."

Several studies released at the conference provide important new evidence of the epidemic's rapid spread among African Americans:

- **AIDS Mortality**: New national mortality data from the CDC will be released at the conference and demonstrate that African Americans continue to represent a disproportionate share of AIDS deaths. Moreover, while deaths have declined among all races, declines in African Americans have been less dramatic than among other races. ***[Data to be released by Helene Gayle, Opening Plenary, Monday, August 30, 8:30 a.m.]***

- **New York City**: A New York City Department of Health study led by Mary Ann Chiasson, Dr.P.H., showed that African-American women comprise 53% of female AIDS cases in the city. In 1998, African-American women diagnosed with AIDS were almost 3 times more likely to die than Hispanic women. The study also showed that African-American gay and bisexual men were almost twice as likely to die of AIDS as white and Hispanic gay and bisexual men. According to Dr. Chiasson, further research is urgently needed to identify the factors associated with these disparities. ***[Abstract #550, "Differential Decline in AIDS Mortality by Gender and Race/Ethnicity in New York City," Monday, August 30, 10:30 a.m.]***

- **Gay Men**: A separate study conducted by David Webb of the Sacramento Department of Health Services, examined 2,638 gay males ages 13-19 accessing HIV testing at state-funded sites in California. Study results indicated that young gay African-American men were at 5.8 times greater risk for HIV infection than other young gay men. ***[Abstract #473, "Risk Factors for HIV Infection Among Adolescent Males Who have Sex with Males in California," Monday, August 30, 10:30 a.m.]***

  Other HIV prevalence and incidence data from multi-city studies released earlier today also demonstrate a disproportionate impact on African Americans.

  The Young Men's Survey, conducted by Linda Valleroy and colleagues, examined young gay men in seven cities and found African-American youth to be infected at a rate nearly 5 times higher than whites in the study. HIV prevalence among the over 3,000 young men sampled was 14.1% among African-Americans, compared to 3% among whites. ***["HIV Incidence Among Young Men Who have Sex with Men in Seven U.S. Metropolitan Areas," Monday, August 30, 3:30 p.m.]***

  Among gay and bisexual men in a six-city study among clients of STD clinics, Hillard Weinstock and colleagues found higher levels of new infection among African Americans (11% per year), when compared to Hispanics (7.7%) and whites (6.5%). ***["HIV Seroincidence Among High Risk Heterosexuals and Men Who have Sex with Men in the U.S. Using a Dual EIA Testing Strategy," Monday, August 30, 3:30 p.m.]***

- **Bisexuality**: Two new studies suggest that bisexual risk behaviors among African-American men may be fueling the spread of HIV infection to African-American women in some parts of the country.

  A survey of 7,065 men in gay venues in New York City, conducted by Tracy Mayne, Ph.D., and colleagues from the New York City Department of Health and Gay Men's

Health Crisis, found 20% of African-American men reporting bisexuality, compared to 12% of Hispanics and 4% of white men. ***[Abstract #707, "HIV Risk Behavior in Gay and Bisexual Men in New York City," Monday, August 30, 3:00 p.m.]***

A study from the Michigan Department of Community Health, led by JoLynn Pratt, interviewed 1,001 HIV-positive African-American men in southeast Michigan and found that 36% of the African-American men who had sex with men also had sex with women.

According to Pratt, the data from these studies indicate that African-American women are acquiring HIV not simply from injection drug users, as is commonly perceived, but also from bisexually active men. ***[Abstract #364, "Using Behavioral Data to Target Prevention Activities in the Black Community," Monday, August 30, 10:30 a.m.]***

- **Drug Users:** A nine-year retrospective review of 87,000 tests administered among people in treatment for all types of drug use, led by Jeffrey Rothman of the New York State Department of Health AIDS Institute, found that African-American injection drug users had an HIV prevalence rate of 19% in 1998, nearly four times that of whites (5%). While the seroprevalence among African-American substance users tested as part of this project has declined by more than 60% since 1990, it has remained consistently higher than that of whites. ***[Abstract #325, "Implementing HIV Prevention Programs in Substance Abuse Treatment Facilities as Part of a Comprehensive HIV Service Model - Eight Year Retrospective," Tuesday, August 31, 1:30 p.m.]***

The Director of the CDC's National Center for HIV, STD, and TB Prevention, Helene Gayle, M.D., M.P.H., said studies presented today underscore the need for renewed support for prevention and treatment efforts in African-American communities. According to Gayle, HIV prevention efforts must take into account cultural issues, as well as social and economic factors – such as poverty, underemployment, and poor access

to the health care system – that impact many U.S. minority communities. Effectively addressing these issues, she says, will require strong partnerships.

"We remain committed to expanding our efforts to combat the epidemic," said Dr. Gayle. "But the complex factors contributing to the disproportionate impact of HIV among African Americans cannot be effectively addressed by the government alone."

"We will need every facet of the African-American community to join us, get involved, and openly address the real challenges we face, in order to stop the spread of the disease that is devastating our community."

CDC Continues to Expand HIV Prevention Programs in African-American Communities

In response to HIV's rapid spread among African Americans, CDC today released an analysis of its programs directed toward African-American communities over the past decade. Since the late 1980s, CDC has worked in partnership with national, local, and regional minority organizations to build its prevention efforts, specifically targeting African Americans, from a level of nearly $11 million in 1988 to over $120 million in 1999.

African-American leaders and the Congressional Black Caucus recently played a key role in obtaining an additional $156 million for prevention programs in the African-American community in 1998, $39 million of which will be administered by the CDC. The CDC will announce the first recipients of these funds this fall.

"By continuing to expand our partnership with African-American communities, we can control the HIV epidemic in the areas it's hitting hardest," said Dr. Gayle. She highlighted several CDC-funded African-American prevention programs:

- To better serve African-American men who have sex with men, Gay Men's Health Crisis organized "Soul Food," a program designed by African-American gay men to help their peers remain HIV negative. This community mobilization effort has enrolled more than 400 African-American gay and bisexual men in New York City, and volunteers have collected more than 1,100 sexual health surveys from African-American gay and bisexual men across the city. These efforts have led to a better understanding of the needs of this population, including more specifically targeted outreach programs that value cultural affiliations, improved community capacity for HIV prevention, an increase in harm reduction counseling, and more holistic programs which support the many needs of an individual.

- "Sisters Together and Reaching (STAR)" is a faith-based organization providing numerous support services that address how to prevent getting HIV, as well as how to live as healthy a life as possible with HIV. One of these services is "Project NIA," a street-based outreach delivered by a mobile van in high-incidence communities throughout Baltimore. Since the beginning of "Project NIA," nearly 2,000 African-American women and men have received at least one service, including peer counseling, referrals for needle exchanges, and HIV/STD testing and counseling.

- "Teen WISE (Women Informed Seeking Empowerment)" reaches young African-American women in settings such as schools, child-care facilities, clinics and stores. The Detroit program uses a variety of activities to increase knowledge about HIV transmission and prevention and to improve safer sex practices and skills among these teens. One important component of "Teen WISE" is the use of peer educators for conducting prevention activities. Educators act as role models for other teens, and benefit themselves from the feelings of empowerment that come from helping others in their community. Other "Teen WISE" activities include street outreach, health education workshops, risk-reduction counseling and support group development.

- "Shelter Women's AIDS Project" serves African-American women who live in or frequent eight transitional and homeless shelters in Chicago. The program is designed to assist women in developing and managing a plan to stay HIV negative. Group education workshops include information on HIV and other sexually transmitted diseases and methods for reducing one's risk of infection, as well as discussions about relationships and substance abuse. Additional service is provided by prevention case managers who work one-on-one with women to help identify factors that impact their decisions to avoid high-risk behaviors. Women served by "Shelter Women's AIDS Project" also are provided referrals for HIV, STD, and TB testing, mental health services, substance abuse treatment, medical care and other social and health services.

- "Sisters and Brothers Prevention Project (SBPP)" targets African-American youth at high risk for HIV infection. Based in Bridgeport, Connecticut, SBPP conducts street outreach – bringing information and materials about HIV prevention, condom use and other risk-reduction behaviors to hard-to-reach youth, including youth who are involved in the sex industry, youth who abuse drugs and alcohol, pregnant youth, homosexual and lesbian youth, runaways and homeless youth. The program also provides referral services for substance abuse treatment and HIV, STD, and TB testing. SBPP is also conducting a pilot program for street-based HIV counseling and testing.

In addition to continuing to expand efforts to reach African Americans, CDC is actively working with Latino communities and others hard hit by the epidemic to build and sustain effective prevention programs.

The National HIV Prevention Conference is convened by the Centers for Disease Control and Prevention and seventeen other sponsoring organizations, including the Office of AIDS Research/National Institutes of Health, National Minority AIDS Council, and the National Association of People with AIDS.

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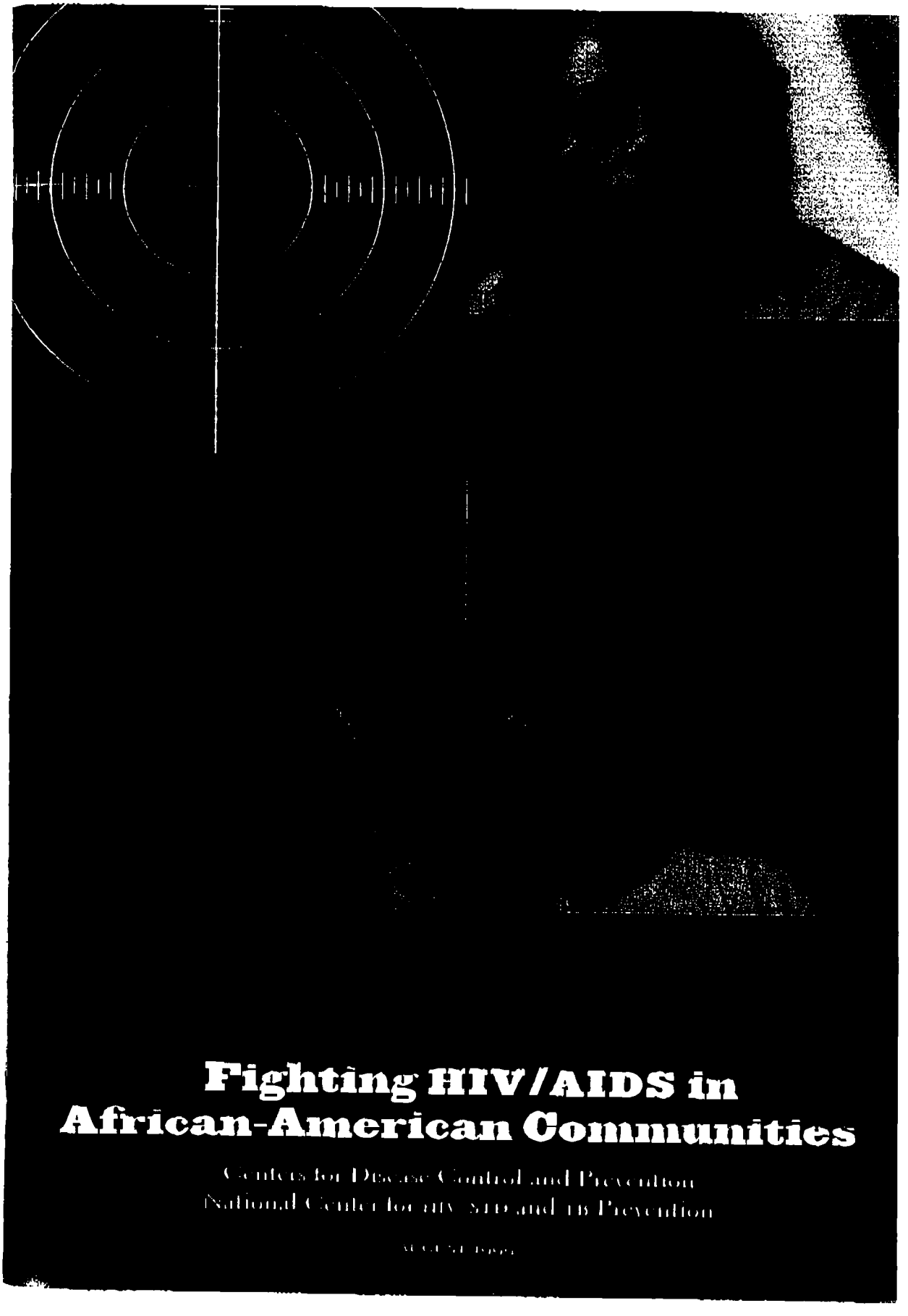
National HIV Prevention Conference
1999 Atlanta, Georgia August 29 - September 1

HIV Prevention Now More Than Ever

The Latest Trends in AIDS Incidence and Deaths, 1995-1998

	1995	1996	1997	1998	% Decline (1995-1996)	% Decline (1996-1997)	% Decline (1997-1998)
AIDS INCIDENCE							
Total	68,734	60,394	49,667	44,289	12%	18%	11%
White	26,617	21,188	15,823	13,836	20%	25%	13%
African American	27,832	26,464	23,165	21,051	5%	12%	9%
Hispanic	13,404	11,896	9,994	8,810	11%	16%	12%
AIDS DEATHS							
Total	49,351	36,792	21,222	17,047	25%	42%	20%
White	21,441	14,160	6,997	5,436	34%	51%	22%
African American	18,496	15,491	10,060	8,316	16%	35%	17%
Hispanic	8,835	6,724	3,934	3,114	24%	42%	21%

Conference Co-sponsors: AID Atlanta ● Academy for Educational Development ● American Social Health Association (ASHA) ● Association of Public Health Laboratories ● Centers for Disease Control and Prevention (CDC) ● CDC Foundation ● Council of State and Territorial Epidemiologists (CSTE) ● Health Care Financing Administration ● Health Resources and Services Administration (HRSA) ● Indian Health Service (IHS) ● National Alliance of State and Territorial AIDS Directors (NASTAD) ● National Association of People with AIDS (NAPWA) ● National Council of STD Directors (NCSD) ● National Minority AIDS Council (NMAC) ● Office on AIDS Research (OAR)/National Institutes of Health (NIH) ● Office on Women's Health/Department of Health and Human Services ● Rollins School of Public Health/Emory University ● Substance Abuse and Mental Health Services Administration (SAMHSA)



Fighting HIV/AIDS in African-American Communities

Centers for Disease Control and Prevention
National Center for HIV, STD and TB Prevention

The spread of AIDS among blacks and Latinos is a "public health emergency... The complexion of the epidemic has changed. Increasingly it is becoming an epidemic of color."

DR. DAVID SATCHER, U.S. SURGEON GENERAL
OCTOBER 29, 1998

Fighting HIV/AIDS in African-American Communities

A Growing Crisis

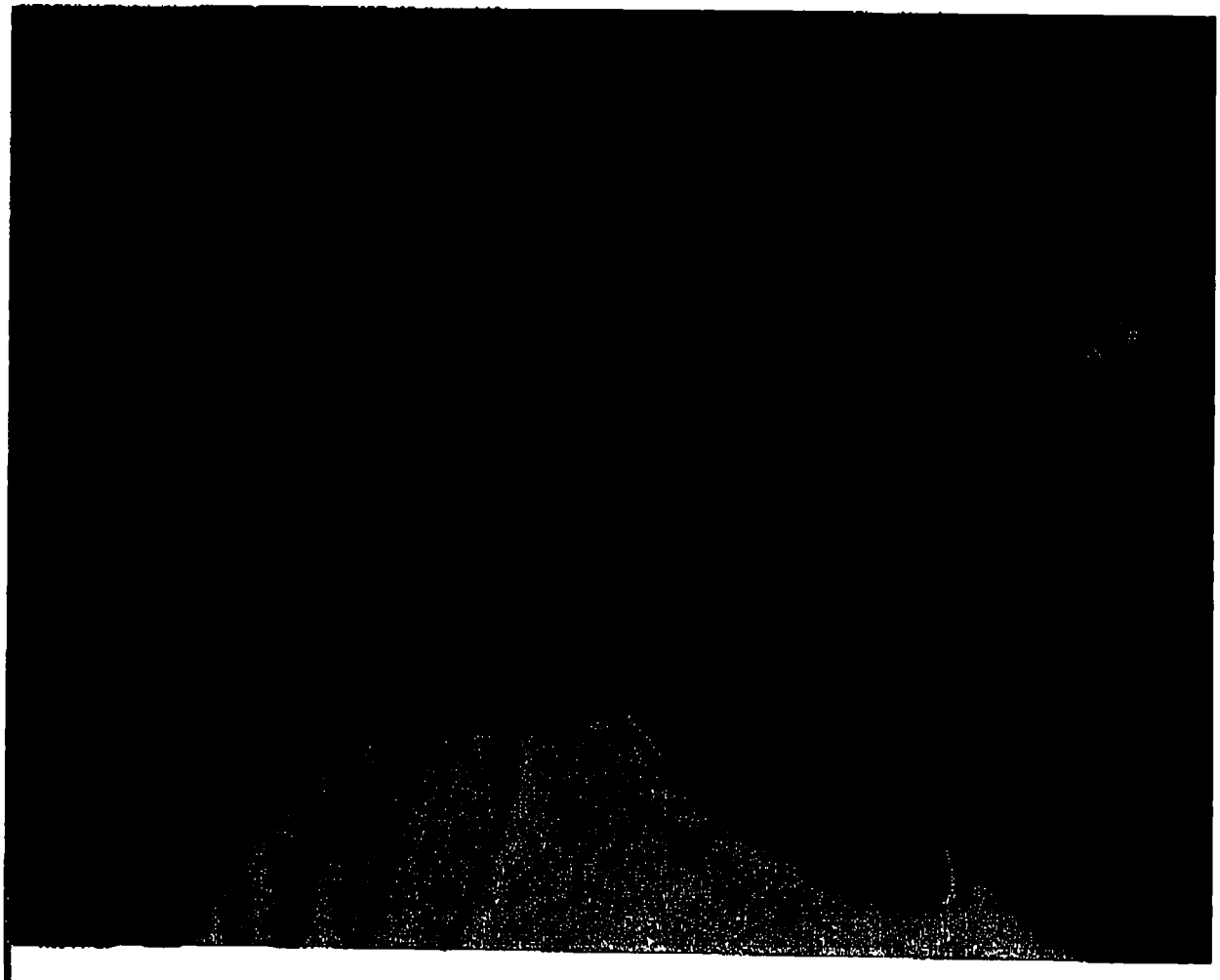
The U.S. HIV epidemic, which began primarily among white gay men over a decade ago, has expanded to affect an increasing number of populations, with African-American communities among those most dramatically affected. Today, the disease poses a fundamental threat to the future health, well-being, and human potential of many African-American communities. African Americans are almost ten times more likely to be diagnosed with AIDS than whites, and there is evidence that this disparity is increasing. Race and ethnicity are not, themselves, risk factors, but correlate with other more fundamental determinants of health status such as poverty, access to quality health care, health care seeking behavior, illicit drug use, and living in communities with high prevalence of sexually-transmitted diseases (STDs). Acknowledging the disparity in HIV and STD rates by race or ethnicity is one of the first steps in empowering affected communities to address this problem.

As a result of the continued growth in HIV/AIDS, African Americans are broadly mobilizing to respond to the epidemic. CDC is committed to working in partnership with African-American communities and other government agencies to ensure that *all* people at risk have access to early testing, treatment, and prevention programs that work. Only through a meaningful, sustained partnership between government and national and local African-American leaders and institutions can this severe and ongoing health threat be brought under control.

Fortunately, extensive prevention science research has demonstrated that sound, science-based prevention programs can significantly reduce the risk of HIV infection among communities at risk. Moreover, an increasing number of African Americans are being reached by STD screening and treatment services known to reduce HIV transmission, and powerful new HIV treatments that may prove to reduce transmission even further.

This report provides basic facts about HIV/AIDS among African Americans and outlines CDC's response to this public health threat. In its efforts to control the spread of HIV nationwide, CDC pursues three basic strategies:

- **Tracking the Epidemic:** CDC carefully monitors the status of HIV/AIDS by race, risk group and gender, enabling communities to base public health strategies on the best possible understanding of the epidemic.



- **Researching Prevention:** CDC conducts extensive biomedical and behavioral research to ensure that HIV prevention programs are based on sound science.
- **Helping Communities:** CDC provides more than $400 million to help communities build and sustain sound, innovative HIV prevention programs. CDC also provides funding and support to enable local communities to deliver the STD treatments that reduce vulnerability to HIV infection.

As African Americans have represented an increasing proportion of individuals affected by HIV infection and AIDS, an increasing proportion of CDC's prevention efforts in all three areas has focused on reaching African Americans. Additionally, CDC has initiated a growing number of national, regional, and community-based programs designed exclusively to reach African-American populations. Working through state and local health departments and directly funded organizations, CDC initiatives have been built in partnership with African-American community and faith-based organizations over time, and have grown from $11 million in 1988 to $137 million today.

Much work remains to be done to turn the tide against HIV/AIDS among African-Africans. As this report makes clear, however, the systems to mount a successful response have been growing, and there is a new commitment among African-American leaders to fighting back against this disease.

Tracking the Epidemic

Close monitoring of the epidemic enables communities to tailor prevention strategies to local needs. Since AIDS first appeared, CDC has collected and disseminated the best available information on disease trends, including racial and ethnic differences among people diagnosed with HIV/AIDS.

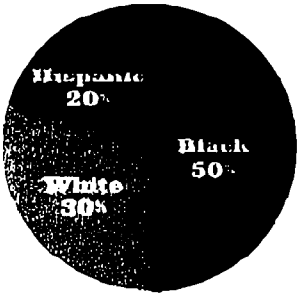
As early as September 1983, it became apparent from CDC's surveillance data that AIDS was disproportionately affecting African Americans. At that time, African Americans accounted for 26% of all AIDS cases, yet represented only 13% of the U.S. population. In CDC's October 1986 report on AIDS among blacks and Hispanics, CDC documented that the cumulative incidence of AIDS among blacks and Hispanics was over 3 times the rate for whites.

As the U.S. nears the end of the epidemic's second decade, the disease burden among African Americans has grown further still.

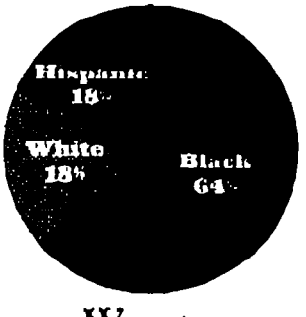
Disease and Death

- Although African Americans made up 13% of the U.S. population, they represented 48% of all reported AIDS cases in 1998.
- AIDS remains the leading cause of death for African Americans ages 25-44.
- Researchers estimate that 240,000-325,000 African Americans are infected with HIV, and more than 106,000 of these individuals are currently living with AIDS.
- Despite declines in AIDS deaths among all racial/ethic groups between 1995 and 1998, AIDS mortality rates remain nearly ten times higher among African Americans than among whites.

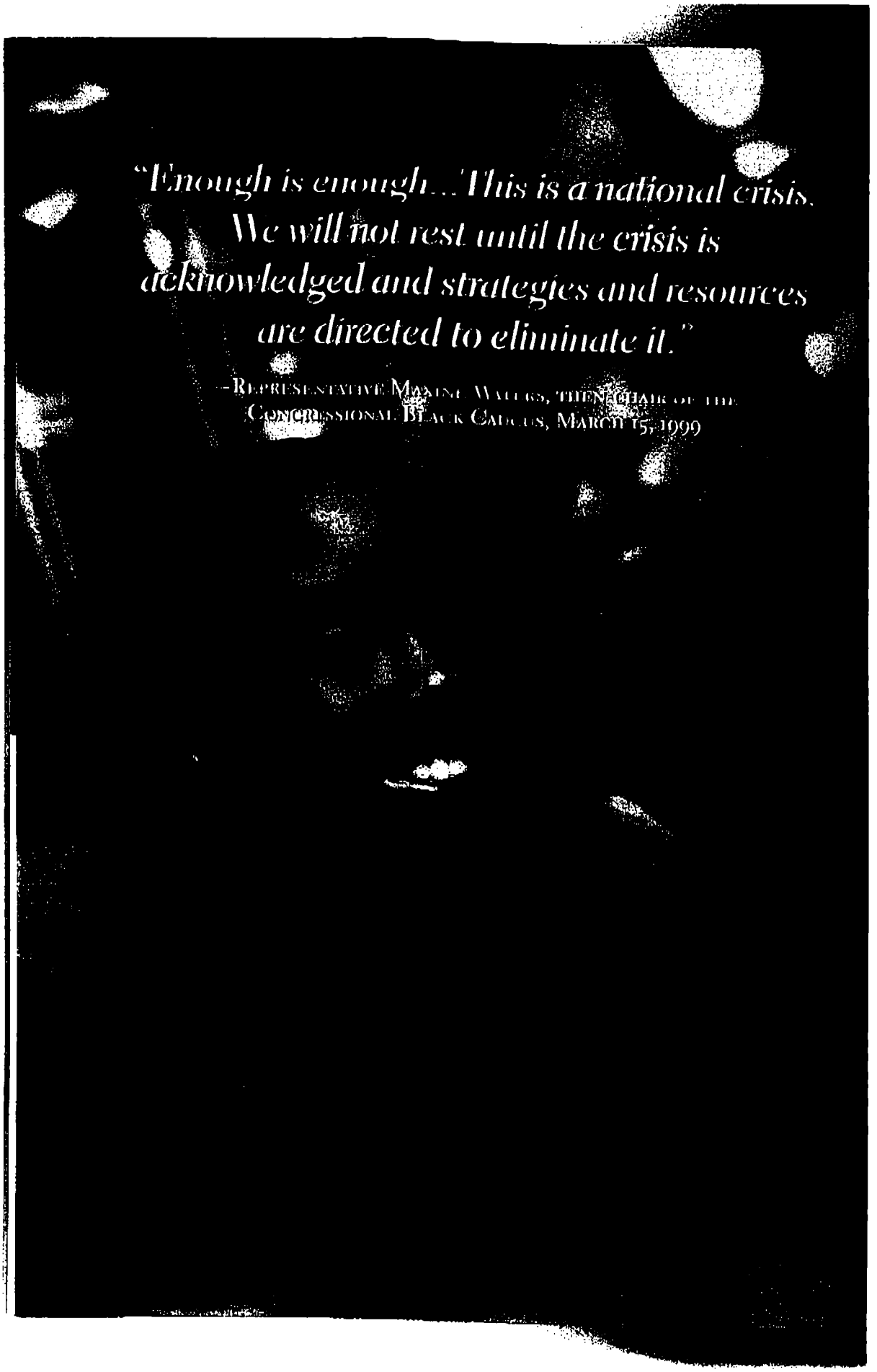
Estimates of New Infections By Gender and Race—1998



Men



Women


"Enough is enough... This is a national crisis. We will not rest until the crisis is acknowledged and strategies and resources are directed to eliminate it."
–Representative Maxine Waters, then Chair of the Congressional Black Caucus, March 15, 1999

Disproportionate Infection Rates

- According to estimates, approximately half of all new HIV infections occur among African Americans.
- Approximately 1 in 50 African-American men and 1 in 160 African-American women are believed to be infected with HIV. By comparison, 1 in 250 white men and 1 in 3,000 white women are believed to be infected.

Dramatic Impact Among African-American Youth

- Estimates of infection trends in the early 1990s indicate that half of all young adults (18-22) infected during these years were African-American.
- A 1998 CDC study of entrants to the U.S. Job Corps found that young African-American women were seven times more likely than their white counterparts, and eight times more likely than Hispanics, to be HIV-infected.
- A 1999 CDC study of young men who have sex with men (ages 15-22) in six urban counties found that African-American men were substantially more likely to be HIV-positive (14%) than Hispanics (7%) or whites (3%).

National HIV Reporting Needed

Current estimates of new HIV infections are rough, and are based on specific studies and data from states that track HIV infections, as well as AIDS cases. Prior to recent treatment advances, AIDS cases were generally accurate indicators of HIV infection, because HIV progressed to AIDS at predicable intervals prior to 1996. Although CDC has called for one, there is currently no national system that tracks new HIV infections the same way that AIDS cases are monitored. Only by tracking new HIV infections will we be able to accurately determine the magnitude of the HIV epidemic and the populations most in need of HIV prevention services.

Researching Effective Prevention Programs

The CDC conducts extensive research to improve the effectiveness of HIV prevention programs. Given the disease's impact on African Americans, a substantial portion CDC's prevention research portfolio focuses on this important population.

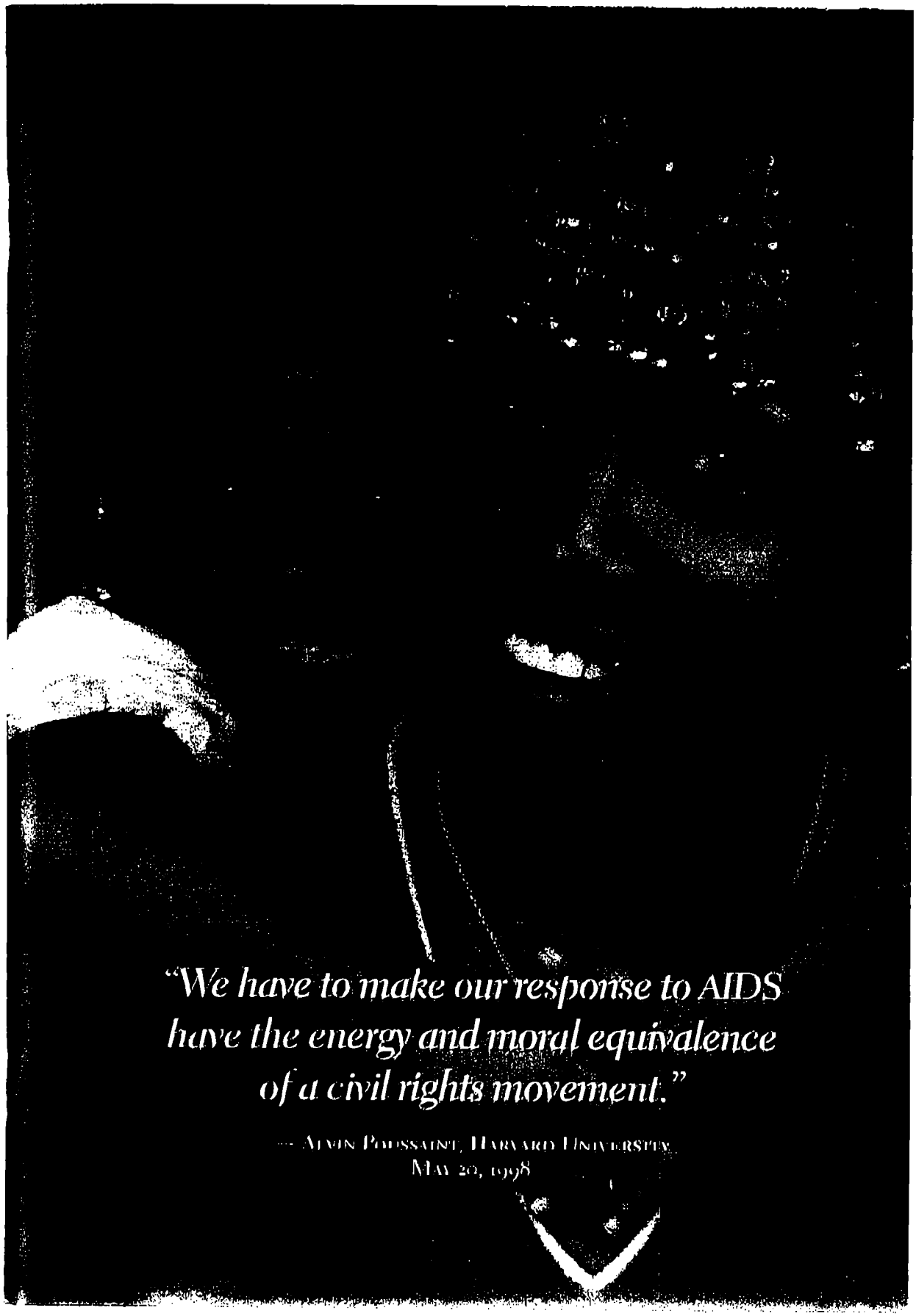
Behavioral Research

CDC studies the behaviors that place people at risk for HIV infection. By better understanding these behaviors, scientists can devise new and better strategies to help those at risk avoid HIV transmissior

- **Developing and Testing Behavioral Programs:** In an effort to expand and improve the range of prevention strategies available, CDC develops and evaluates behavioral interventions to determine if they are effective at reducing HIV risk. Among a group of largely African-American and Hispanic women seen in STD clinics, for example, CDC found that an improved counseling technique could significantly reduce new STDs. The 1998 study found th STD clinic patients who received brief, interactive counseling sessions had 20% fewer STDs than those given non-interactive educational sessions.

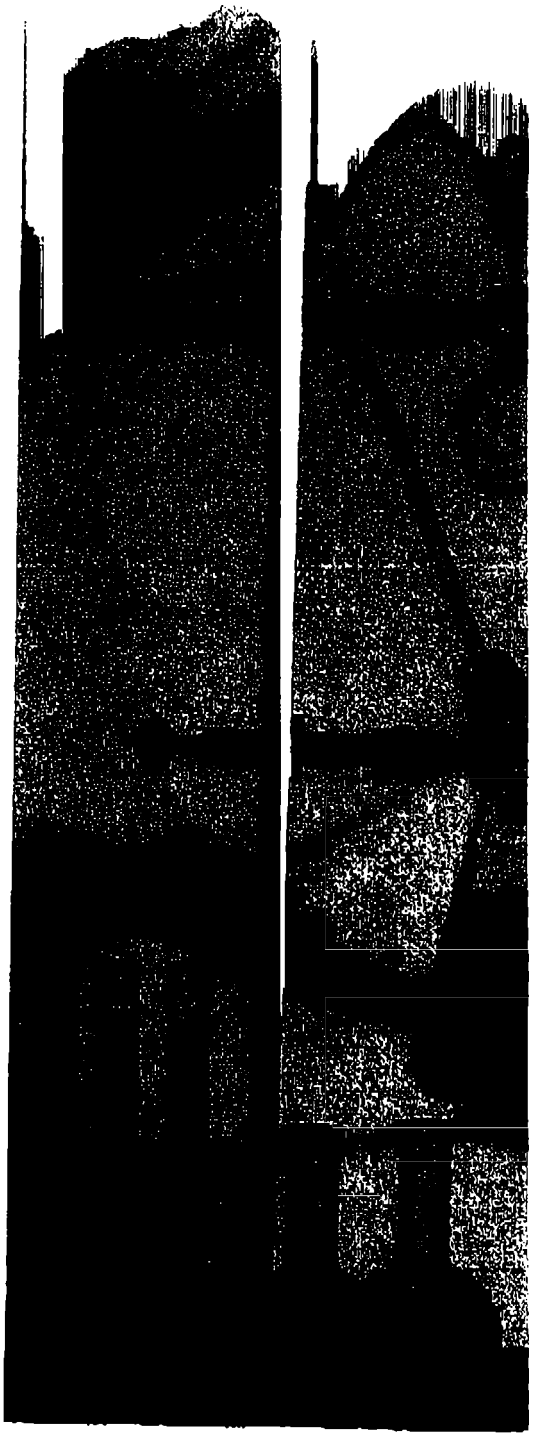
- **Educating Women:** CDC recently completed the HIV in Women and Infants Project, a community-level behavioral intervention project targeting young women ages 15-34. The project was designed to improve the understanding of factors influencing women's behavior changes regarding condom and contraceptive use, and to improve the development and delivery of prevention interventions. Given that African Americans comprise the majority of HIV/AIDS cases among women and children, this project will result in important preventive benefits for African-American communities.

- **Preventing HIV Among Young African-American Men:** CDC also conducted the Young African-American Men's Study, a two-year study to prevent HIV/AIDS in young African-American men. Other ongoing CDC research projects are seeking to better understand risk behaviors and design effective interventions for injection drug users, women who partner with injection drug users, individuals with high rates of STDs, and young gay and bisexual men of color.


"We have to make our response to AIDS have the energy and moral equivalence of a civil rights movement."
— Alvin Poussaint, Harvard University
May 29, 1998

Biomedical Research

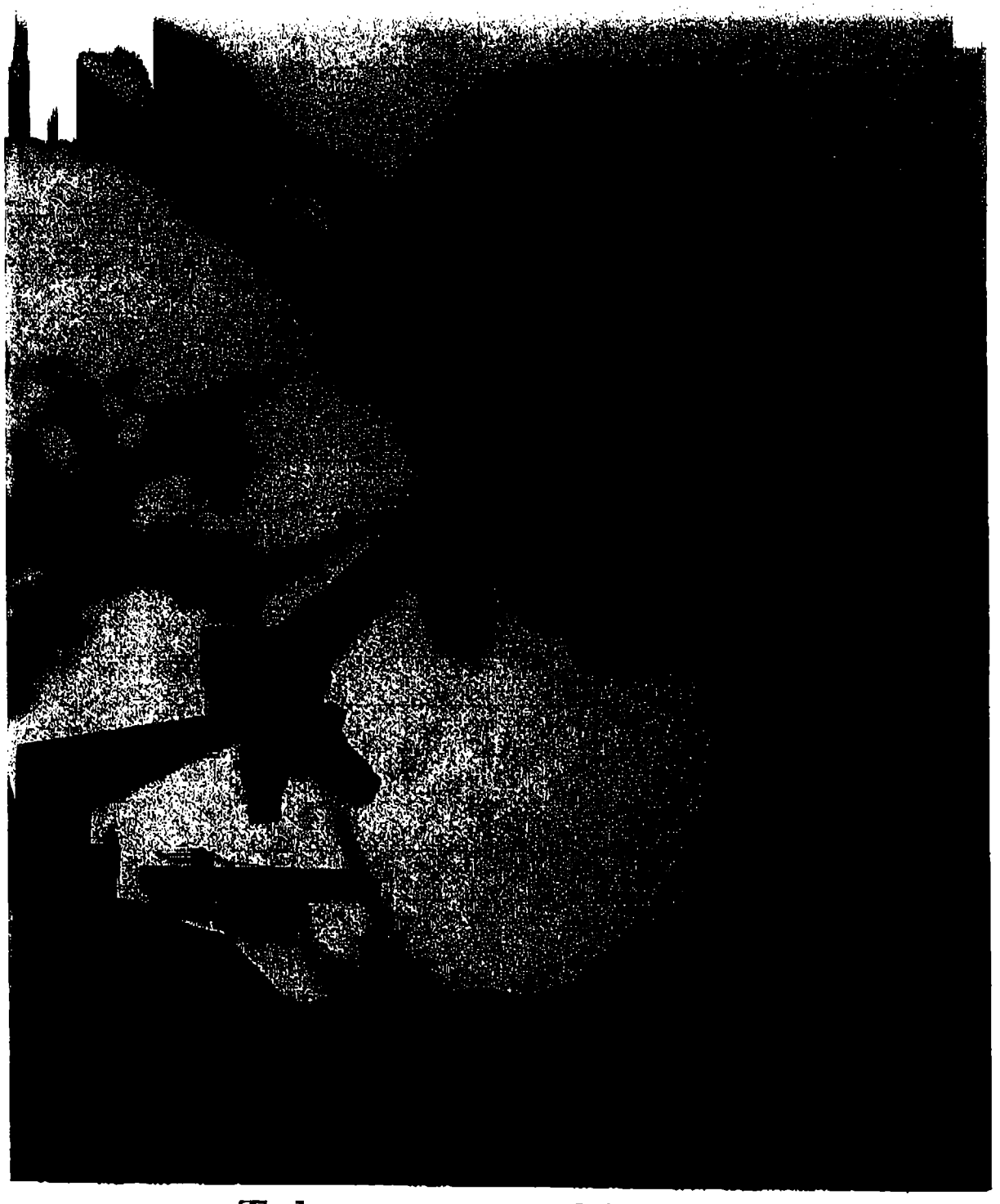
Biomedical treatments that reduce the likelihood of HIV transmission support and enhance the effectiveness of behavior change programs. CDC conducts important research on numerous biomedical strategies to prevent transmission.



- **Mother-to-Child Transmission:** In 1994 research showed that AZT therapy given to HIV-infected pregnant women from the 14th to 34th week, continuing throughout pregnancy, during labor and delivery, and to the child for six weeks after birth could significantly reduce perinatal HIV transmission. Since that time, CDC has been working with health care providers across the nation to ensure the widespread implementation of voluntary HIV testing and treatment for all HIV-infected pregnant women. Today, antiretroviral therapy has helped to reduce the number of U.S. infants who acquire AIDS by 73% from 1992 through 1998. These efforts have been critical for reducing the toll of HIV among African-American infants, who represent over 60% of all infants born with HIV.

- **HIV and STD Treatment:** As the nation's leader in STD prevention and treatment, CDC also conducts research on the impact of STD treatment on HIV transmission. Today, an increasing number of African Americans are being reached with STD screening and treatment services known to reduce HIV transmission, and are gaining access to new antiretroviral HIV therapy that may prove to reduce transmission even further. Additionally, CDC researchers are seeking to determine whether combination antiretroviral therapy actually reduces the risk of HIV transmission.

- **Microbicides and Vaccines:** CDC is also extensively engaged in research efforts to discover effective microbicides and to develop a preventive HIV vaccine. Moreover, CDC is working to determine the factors that influence willingness to use those approaches and how their development may influence risk behaviors.



Today, antiretroviral therapy has helped to significantly reduce the number of newborns infected with HIV in the U.S.

The Impact of HIV/AIDS in Af

July 1982 – CDC reports that 37 cases of AIDS-related pneumonia have occurred among African Americans

1984 – HIV is identified as the cause of AIDS

June 1984 – CDC reports that 50% of all pediatric AIDS cases are among African Americans

1985 – CDC begins providing funds to state and local health department HIV prevention efforts

October 1986 – CDC issues special *Morbidity and Mortality Weekly Report* on "AIDS Among Blacks and Hispanics," finding that African Americans account for 51% of all AIDS cases among women and have an overall AIDS rate three times higher than whites

1987 – CDC begins earmarking a portion of its state and local health department funding for African Americans and other minorities

1988 – CDC begins providing funding to National and Regional Minority Organizations and to the faith community

July 1988 – In a special surveillance report, CDC finds that African Americans account for 70% of all AIDS cases among heterosexual men, 70% of those in women, and 75% of those in children

1989 – CDC begins direct funding for community-based organizations serving African Americans to help close gaps in access to HIV prevention services in underserved communities

August 1989 – CDC reports on first 100,000 AIDS cases

1990 – CDC issues surveillance reports on HIV/AIDS among IV drug users, children and women, noting disproportionate impact on African Americans

August 1992 – CDC report on publicly-funded counseling and testing reveals substantially higher HIV-positive rate among African Americans than among whites

...s in African-American Communities

1988 – CDC funds a U.S. Conference of Mayors study to assess the HIV prevention needs of gay and bisexual men of color

November 1988 – CDC reports that HIV has become the leading cause of death for African-American women ages 25-44 and the second leading cause of death for African-American women in the same age range

December 1988 – CDC begins requiring state and local health departments to ensure that local communities have input into making decisions about how HIV prevention funds are used

September 1989 – CDC issues special MMWR report on AIDS among racial and ethnic minorities

1994 – CDC publishes recommendations on use of AZT to reduce mother-to-child transmission

1995 – CDC report on AIDS among men who have sex with men notes that African-American men have highest AIDS incidence of all racial/ethnic groups

1995 – CDC publishes recommendations for voluntary HIV counseling and testing for pregnant women

1996 – CDC reports that in 1994 HIV had become the leading cause of death for African-American women, ages 25-44, and remained the leading cause of death for African American men in the same age range

1998 – African-American community leaders join with Congressional Black Caucus to obtain substantial new funding for HIV prevention services in the African-American community

1998 – CDC assessment of community planning finds an increase in the share of funds directed toward African Americans

1999 – With additional support for prevention activities in the African American community, CDC begins the process of distributing funds for new HIV prevention initiatives

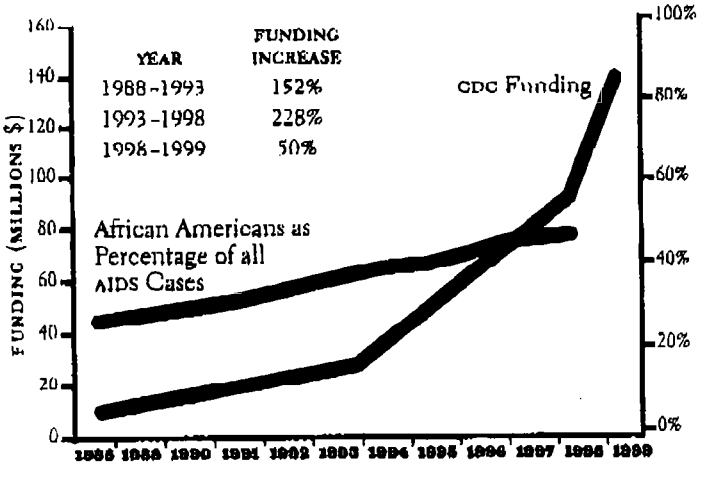
Helping Communities Fight HIV

As HIV has increasingly targeted more and more sub-populations at risk, the national effort to bring the epidemic under control has become more complex. HIV prevention efforts must take into account cultural issues, as well as social and economic factors—such as poverty, underemployment, and poor access to the health care system—that affect many U.S. minority communities. Effectively addressing these issues requires strong partnerships and building basic services that often do not exist.

CDC has devised numerous strategies to strengthen the nation's response to HIV/AIDS in African-American communities. Recognizing the epidemic's disproportionate impact on African Americans, CDC began building partnerships in the late 1980s with community-based organizations and faith communities to reach African Americans at risk of infection.

Over the past decade, these efforts have grown substantially. Today, hundreds of community-based organizations throughout the nation receive CDC funds for HIV prevention activities directed to the African-American community.

Targeted Funding for African-American Communities Has Dramatically Increased



Unfortunately, as the sub-populations affected have increased, and the national HIV prevention effort has become more complex, overall funding for HIV prevention activities has remained flat for much of the 1990s.

Even still, CDC funding for HIV prevention programs for specific African-American initiatives has grown from nearly $11 million in 1988 to $137 million in 1999 (See graph). In the last year alone, funding for African-American prevention programs grew by more than 50%. As a result, CDC currently directs the largest share of its community-based HIV prevention efforts to African-American communities.

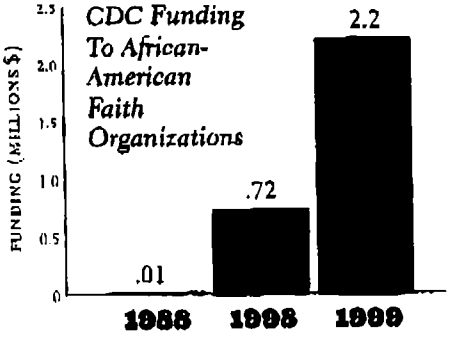
These funds have closely followed the growing proportion of the epidemic in African-American communities. As African Americans make up an increasing share of AIDS cases, a greater and

greater share of CDC's prevention budget has been specifically devoted to fighting the epidemic among this population.

CDC's analysis of HIV prevention funding reveals that the single most important factor in the growth of HIV prevention spending earmarked for African Americans is CDC's initiation of community planning, in which control over CDC grants to local community-based organizations was given to the communities themselves. Community planning alone, instituted in 1993, has resulted in a 228% increase in the amount of federal dollars devoted to HIV prevention services for African Americans.

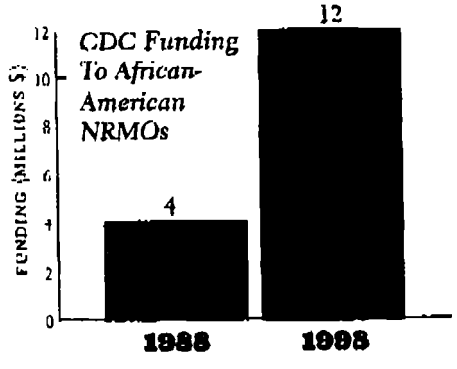
1987 Faith Initiatives

Since 1987, CDC has served African Americans through direct support to the faith community for HIV prevention activities. Funding for African-American faith-based organizations has grown from $10,000 in 1988 to $720,000 during 1998. In 1999, CDC funding to the African-American faith community will increase to $2.2 million.



1988 National and Regional Minority Organizations

In 1988, CDC began providing HIV prevention grants to national and regional minority organizations (NRMOs) to provide the consultation and training needed to help organizations build long-term capacity in communities of color. Funding for NRMOs serving African-American communities has grown from about $4 million in 1988 to over $12 million in 1998. In 1999, CDC will fund a new initiative to significantly increase capacity-building efforts in African-American communities.

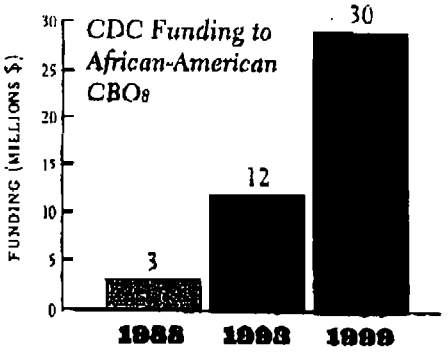


CDC-funded NRMOs that specifically serve the African-American community include:

- National Organization of Black County Health Officials
- National Minority AIDS Council
- National AIDS Minority Information and Education Program
- National Council of Negro Women

1989 Directly-Funded Community-Based Organizations

Although CDC has historically supported community-based organizations (CBOs) through its prevention funding to state and local health departments, CDC has long recognized the need to provide additional support for the HIV prevention infrastructure in hard-hit, underserved communities. In 1989, CDC began providing direct support to local organizations to deliver essential HIV prevention services.



Among the first organizations directly funded by CDC in the early 1990s, 55% targeted African Americans. More recently, CDC in 1997 awarded multi-year contracts to 94 local organizations, 76% of whom directly serve African Americans. CDC's direct CBO funding for HIV prevention services targeted to African Americans has grown from approximately $3 million in 1989 to $12 million in 1993 to $30 million in 1999.

1993 Community Planning

In 1993, CDC made its most profound change in prevention funding, when it put decisions about state and local funding in the hands of affected communities. Through community planning, CDC helps ensure that limited prevention funding goes to those who need it the most.

A CLOSER LOOK

The Sisters and Brothers Prevention Project

SBPP, based in Bridgeport, Connecticut, conducts street outreach—bringing information and materials about HIV prevention, condom use and other risk-reduction behaviors to hard-to-reach young people. Targeting African-American youth at high risk for HIV infection—including those involved in the sex industry, young people who abuse drugs or alcohol, pregnant youth, homosexual and lesbian youth, runaways and homeless youth—the program also provides referral services for substance abuse treatment and HIV, STD and TB testing.

The largest share of CDC's overall HIV prevention spending—$256 million in 1999—flows to state and local health departments through the community planning process. These funds support health education and risk reduction programs, as well as counseling and testing services.

Representation of Local Communities

To ensure that essential community voices were heard in setting prevention priorities, CDC requires that community planning bodies include appropriate representation of hard-hit communities. A CDC analysis of the membership of community planning groups for 1998 and 1999 found that 27% of planning group members were African-American—substantially below African Americans' share of people living with AIDS (39%).

As a result of this analysis, CDC this spring began comparing planning group membership to the epidemiologic picture in each jurisdiction and providing this information to state and local health officials. Areas that have not yet closed demographic gaps in membership are receiving assistance to ensure adequate representation.

Funding to Match the Epidemic

To obtain information regarding the impact of community planning on the targeting of CDC-supported HIV prevention programs, CDC analyzed state and local prevention spending patterns. CDC found that, between 1997 and 1998, the percentage of behavioral prevention program funding (specifically for health education and risk reduction) targeted to African Americans increased from 31% to 37%, a proportion that approached African Americans' share of people living with AIDS (39%)

For HIV counseling and testing activities, health departments projected that the percentage of such spending directed to African Americans would increase from 23% in 1997 to 29% in 1998. These projections, however, may understate African Americans' use of CDC-supported counseling and testing. In 1997, African Americans actually accounted for 52% of all positive HIV test results in CDC-supported test sites.

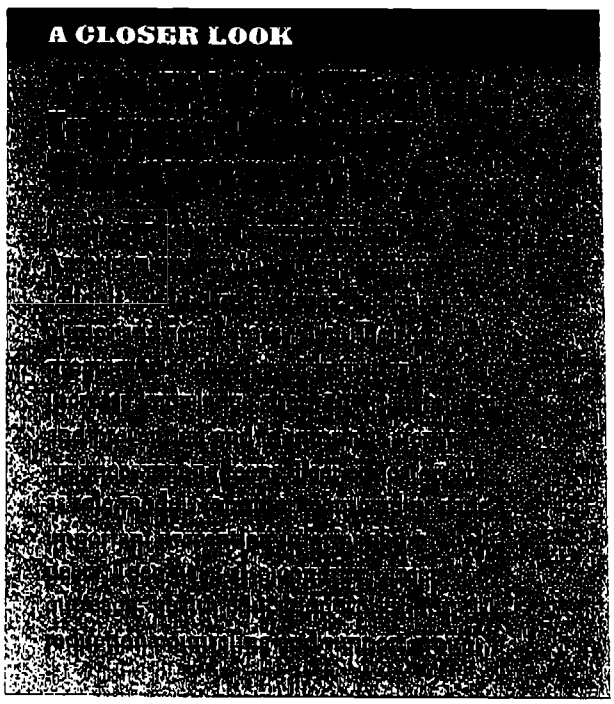
To ensure an appropriate, and scientifically-sound, targeting of African-American communities and others at heightened risk, CDC has adopted a "hard triggers" policy that makes sure that state or local prevention plans that depart significantly from local epidemiologic data are investigated and problems corrected. CDC is actively working with communities where African Americans are underserved to ensure that African Americans at risk for HIV receive the prevention services they need.

A CLOSER LOOK

Soul Food, Brothers Healing Brothers

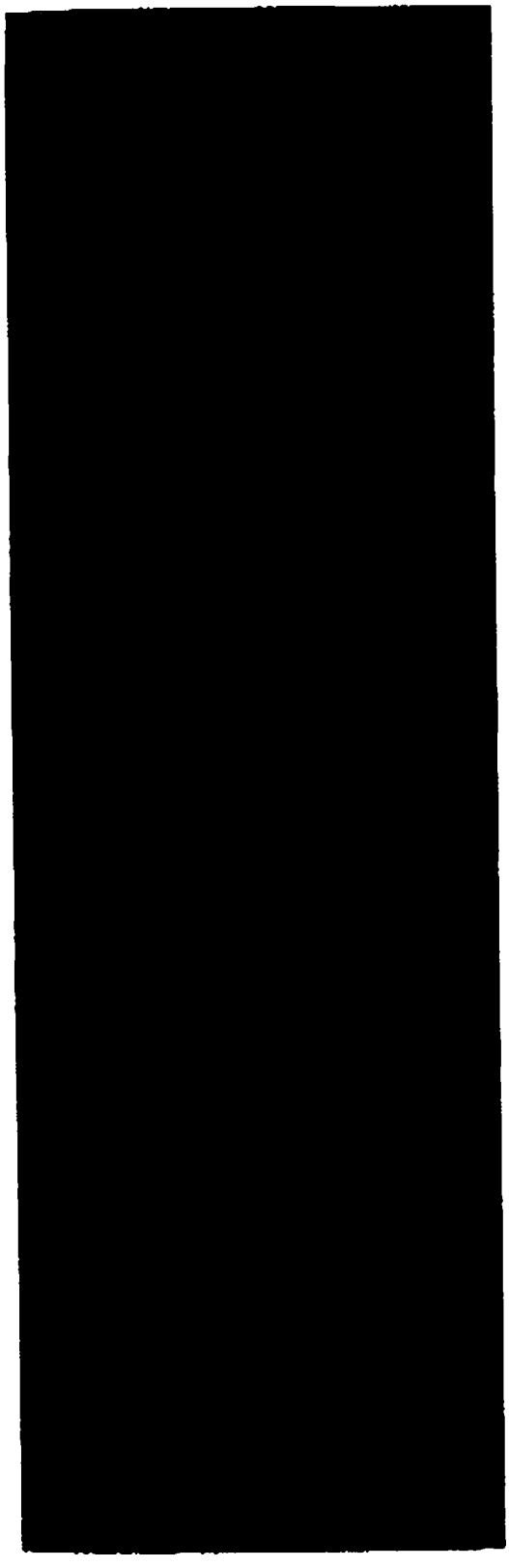
With the support of CDC, Gay Men's Health Crisis in New York City organized Soul Food, a program designed by black gay men with the goal of helping other black gay and bisexual men and their partners remain HIV-negative. The community mobilization effort has enrolled more than 400 black gay and bisexual men, who have collected more than 1,100 sexual health surveys from other such men across the city. These efforts have led to a better understanding of the needs of this population, including more specifically targeted outreach programs that value cultural affiliations, improved community ability to implement HIV prevention programs, and increased counseling of IV-drug users.

A CLOSER LOOK



"The response to the epidemic will demand a genuine, long-lasting partnership between CDC and African-American communities."

DR. HELENE GAYLE, DIRECTOR
NATIONAL CENTER FOR HIV, STD AND TB PREVENTION, CDC



1998 New Initiatives—New Funds

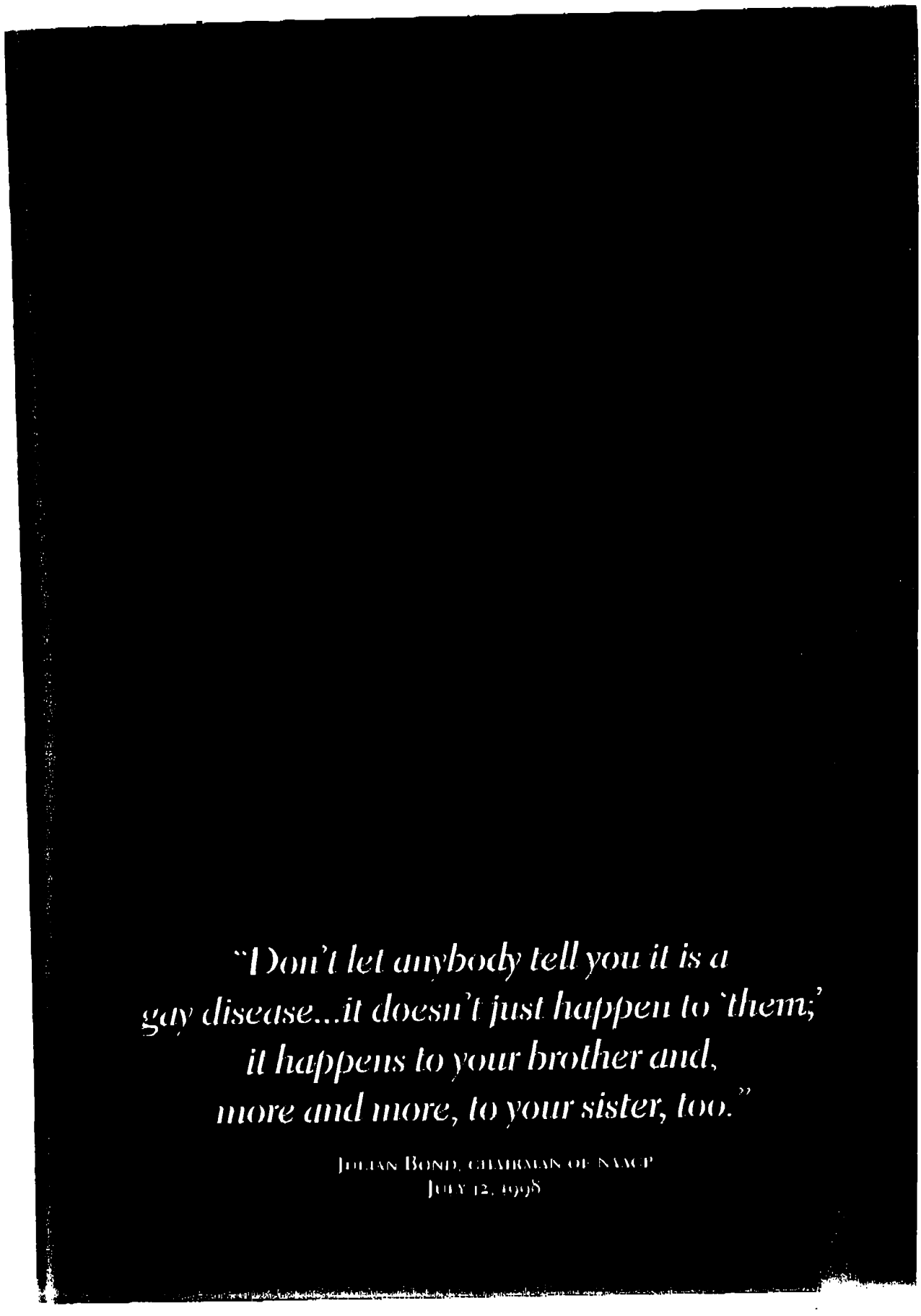
CDC's efforts to work in partnership with African-American communities were greatly strengthened in 1998, when African-American community leaders joined with the Congressional Black Caucus to obtain substantial new prevention funding targeted to African Americans at risk of HIV infection.

As a result of these efforts, CDC received $18 million in new prevention funding for African Americans and $21 million in emergency funding to address prevention needs of communities of color. In addition, CDC received $10 million in funding to support efforts to reduce mother-to-child HIV transmission, which disproportionately affects African Americans. Of these combined funds, a total of nearly $41 million is specifically targeted to African Americans.

Specifically, this new funding will enable CDC to:

- Support approximately 45 additional community-based organizations for prevention services targeted to African Americans ($10 million).
- Enhance the capacity of underserved communities to provide HIV prevention services ($9.7 million).
- Expand efforts to reduce mother-to-infant HIV transmission, nearly 60% of which occurs among African Americans. ($6 million)
- Award grants for HIV prevention services for African-American gay men ($5.6 million)
- As part of a broader strategy designed to reduce HIV transmission through enhanced health care access, undertake extensive activities to encourage African Americans at risk of infection to learn their HIV status, and ensure that infected individuals are referred to treatment and prevention services (Know Your Status campaign: $4 million).
- Increase prevention services to reach high-risk minority populations in correctional facilities ($4 million).
- Increase HIV prevention activities in the faith community ($1.5 million)

	1988	1993	1998	1999
State and Local Health Departments (Community Planning)	5.75	8.43	66.22	66.22
Capacity Building and Technical Assistance				22.84
Community-Based Organizations		11.85	14.64	30.00
Faith Initiative	0.01	0.10	0.72	2.22
Other Minority Initiatives		1.80	3.56	1.73
Mother-to-Child Transmission				6.00
Correctional Facilities				4.00
Know Your Status				1.00
TOTAL	**10.93**	**27.53**	**90.23**	**136.93**


"Don't let anybody tell you it is a
gay disease...it doesn't just happen to 'them;'
it happens to your brother and,
more and more, to your sister, too."
JULIAN BOND, CHAIRMAN OF NAACP
JULY 12, 1998

Conclusion

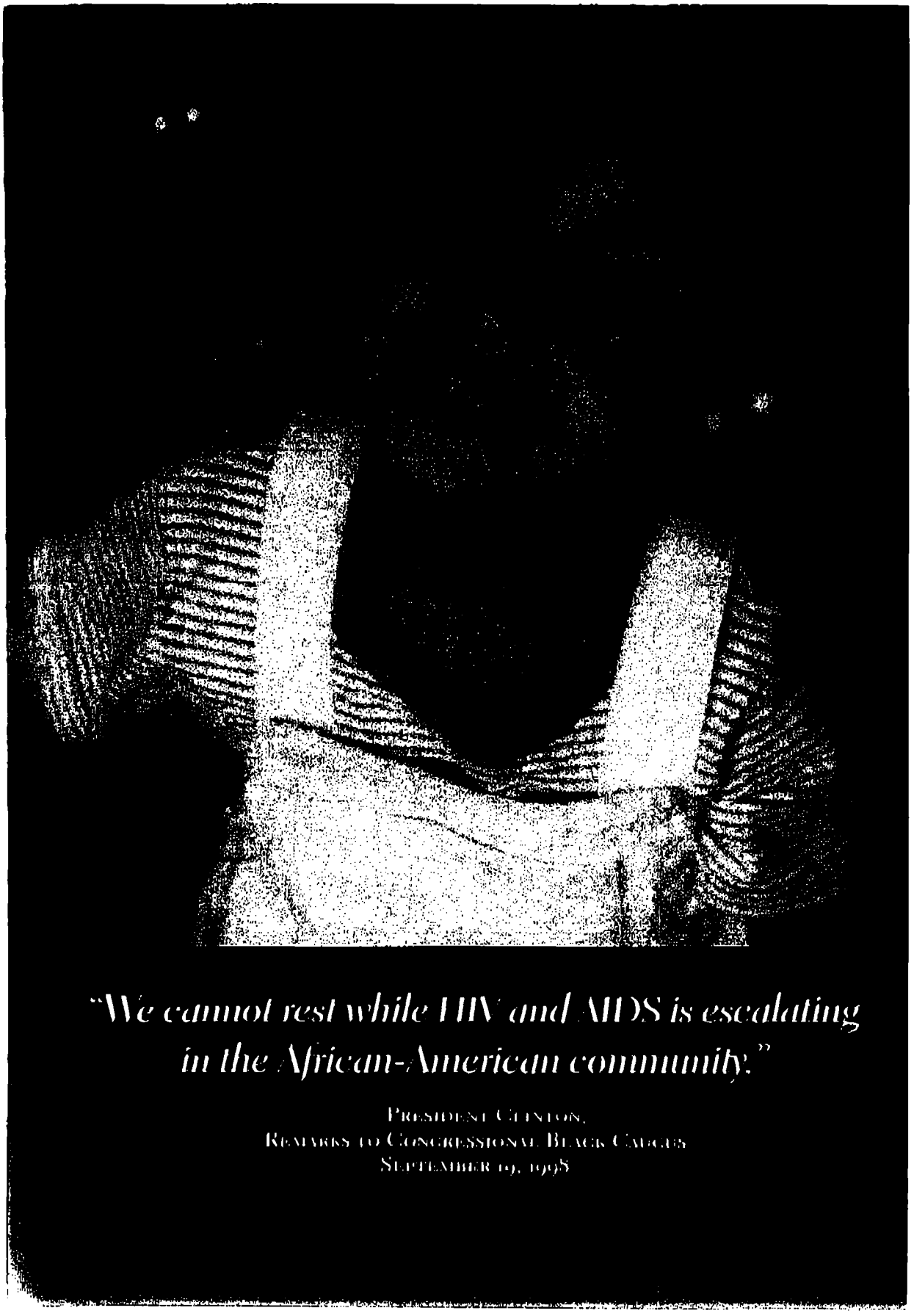
No single community can, on its own, cope with the immensity of the HIV/AIDS tragedy. This may be especially true for communities that have been historically underserved, such as African Americans. Nor can CDC, or state and local health departments, turn the tide against HIV/AIDS without the active involvement of African-American leaders and institutions.

Overcoming barriers to HIV prevention among African Americans will not happen overnight. It will require a sustained community mobilization against the disease, supported by sound, scientifically-grounded prevention strategies, and a national commitment to expanded access to HIV prevention and care. As HIV and AIDS increasingly expand to disadvantaged communities, the response to the epidemic will demand a genuine, long-lasting partnership between CDC and these communities.

As CDC enters the next era, the agency will continue to expand its efforts to reach African Americans, by increasing programs that:

- Reach uninfected people at risk
- Reach infected people with HIV testing, treatment referrals, and sustained prevention
- Build capacity among community organizations and the faith community, recognizing that the ability to deliver prevention and treatment is not the same in all communities.

The many CDC programs outlined in this report are intended to nurture, strengthen, and support mobilization against the disease, and to forge an effective, enduring partnership between African-American communities, CDC, and the public health agencies and local organizations supported with CDC funds.



"We cannot rest while HIV and AIDS is escalating in the African-American community."

PRESIDENT CLINTON,
REMARKS TO CONGRESSIONAL BLACK CAUCUS
SEPTEMBER 19, 1998

The Boston Globe boston.com

Metro | Region

Black groups turn focus to AIDS fight

Area churches deciding to tackle problem

By Sara Neufeld, Globe Correspondent, 08/23/99

One Sunday early last year, the Rev. Hessie L. Harris stood in front of several hundred members of his African-American congregation and asked anyone who had HIV or AIDS or loved someone with the disease to stand and approach the pulpit.

Two-hundred congregants stood.

"I said, `We love you and we're concerned with the things you're dealing with on the inside,'" said Harris, pastor of the Born Again Evangelistic Outreach Ministry in Mattapan.

The Rev. Tina T. Saxon takes a straightforward approach to AIDS education at her Jamaica Plain Church. (Globe Staff Photo / Janet Knott)

The episode was jolting, but not because so many people in Harris's church were dealing with the disease - statistics show that the black population in the United States is affected by AIDS in numbers hugely disproportionate to its size.

Rather, what was surprising was Harris's willingness to acknowledge AIDS inside the walls of an African-American church.

More and more black religious leaders, such as Harris, are saying black churches can no longer turn a blind eye to a disease killing people in their pews or in their neighborhoods. And they are starting to team up with AIDS groups and the state to begin using religious congregations as a launching pad for programs to combat the disease.

Tomorrow, 26 local black religious leaders are scheduled to meet with officials from the AIDS Action Committee and the state Department of Public Health to discuss ways to educate their congregations about HIV and AIDS.

Such concern has been hard to come by in the black church since the outbreak of HIV, the virus that causes AIDS, largely because of the

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entrenched belief that AIDS is a white, gay man's disease, AIDS activists and religious scholars say.

AIDS has wreaked havoc among populations - gays and intravenous drug users - that have historically been treated like sinners and shunned by many black churches, scholars and activists say.

But as the virus continues to claim a devastating toll among African-Americans - who in 1997 made up 13 percent of the US population but 57 percent of new HIV cases that year - the black church is finally responding to this alarming wake-up call. In Massachusetts, blacks account for 26 percent of all AIDS cases, but make up only 6 percent of the population.

"They (black churches) can no longer deny the fact that AIDS touches the black community in ways that go beyond the bounds of homosexual culture, of drug culture," said Quinton Dixie, who teaches black religious history at Indiana University.

But the recognition by black churches of the effect of AIDS on the black community has taken too long, said Pernessa C. Seele, founder and chief executive officer of the Balm in Gilead, a New York-based group that works to raise awareness about HIV and AIDS among black congregations nationwide.

In the Boston area, for example, only about 90 of 450 black churches promote HIV awareness, said Belynda Dunn, who founded and manages the Who Touched Me Ministry, an AIDS Action Committee program that helps black churches educate congregants about the disease.

Nationally, AIDS is the leading cause of death for black men and women ages 25 to 44, and one out of every 50 black men and one out of every 160 black women in America are infected with HIV.

"We're getting ready to get into the third decade of HIV, and we're just beginning to mobilize our community," said Seele, whose organization every year sponsors the Black Church Week of Prayer for the Healing of AIDS in cities nationwide, including Boston.

Seele attributed the delayed response and high infection rate to denial among blacks and lack of attention from government officials. She said other groups hit with AIDS early on - namely white, gay men - had the financial resources necessary for effective education campaigns in their communities.

And according to Dixie, "African-Americans are slow to seek any sort of medical treatment for all sorts of illnesses, partly because there is this very deep faith in the community."

At tomorrow's meeting, pastors will begin planning Boston's week of prayer scheduled for March 2000.

Mobilization, Seele added, has to come from the pulpit because "in the

black community, the church is the center of life."

From the days of slavery to separate water fountains, blacks have always turned to the church - the one institution they could always count on - for spiritual and physical healing, said the Rev. Conley Hughes, pastor of the South End's Concord Baptist Church.

This religious haven has spawned several hallmarks of black achievement such as the civil rights movement and a number of black colleges, said Hughes, who is one of the pastors involved in this week's meeting.

And most blacks, Hughes added, are more likely to listen to a message about AIDS from churches because they consider the church to be society's most credible source of authority.

But until now, black churches have mostly shied away from confronting AIDS.

When Dunn, who is HIV-positive, started her AIDS ministry seven years ago, she had so much trouble getting several ministers to even discuss the subject that she met with their wives instead, she said.

"If you're a minister, you should embrace anyone with any disease," Dunn said. "I had ministers tell me HIV was a punishment from God."

Pastors who will be involved in tomorrow's conference said many parishioners did not support AIDS education and ministry until they realized that the problem was in their own homes.

"As people within the churches began to look around and see their own children and their grandchildren falling because of full-blown AIDS, then they began to think differently," Hughes said.

But one activist said support from pastors and congregants came about only when AIDS started affecting heterosexuals.

"It's all right if it's a gay population that dies," said the Rev. Irene Monroe, a doctoral candidate at Harvard Divinity School who is openly gay. "It's a travesty to them if their heterosexual population begins to die. You can salvage their souls, but you cannot salvage the souls of black queers."

She said many black gays do not go to church because they feel unwelcome.

Historically, most African-American denominations have taken a strictly conservative approach when it comes to a personal code of conduct. As a result, many black religious leaders believe that homosexuality, intravenous drug use, and premarital sex are sacrilegious.

As recently as the 1980s, Dixie noted, pregnant, unmarried teenagers were made to stand before their congregations and ask for forgiveness.

But the state Department of Public Health says that black churches can play a crucial role in the battle against AIDS, despite the challenges posed by the church's conservative theology, said Jean McGuire, director of the agency's AIDS bureau.

Pastors, however, do not have to change their beliefs on controversial issues to educate their congregations about AIDS, Seele said.

"Their responsibility to save lives has nothing to do with their theology on homosexuality or sex outside of marriage," Seele said. "We're talking about two different apples."

Some pastors confronting the AIDS crisis are indeed changing their views.

At the Disciples Baptist Church in Jamaica Plain, the Rev. Tina T. Saxon now discusses once-taboo issues, such as condom use, with young members of her congregation. She said Dunn, one of her congregants, persuaded her to be as honest as possible.

"I get very specific and very graphic," Saxon said. "We cannot really help people if we stay in the ideal mindset. You have to understand where they are and meet them, and then try to bring them to a higher consciousness."

Saxon said she has combined her preaching on prevention with compassion for those who are sick. By making it clear that she will support her congregants no matter what, Saxon has created a comfortable atmosphere in which church members have sought her advice when HIV tests have turned up positive.

"We're all God's people, and I will pray with and try to help anybody," Saxon said.

Dunn believes that praying with Saxon is working for her. Recently diagnosed with hepatitis C, a disease that causes liver inflammation, she can no longer take medication to prevent the onset of full-blown AIDS. So she turns to Gospel for support.

"I've got the energy of about 500 people," she said. "The doctors don't have a clue why I am so healthy."

The name of her project, the Who Touched Me Ministry, comes from the Bible and reflects Dunn's faith in spiritual healing and also how black churches could reach out to those dealing with HIV and AIDS.

In the Gospel of Mark, Dunn noted, a woman cast out from society because she has been bleeding for many years reaches out to touch Jesus's cloak as he passes by. Surrounded by his followers, Jesus stops and asks, "Who touched me?"

"He felt her spirit through his garment," Dunn said. "And the blood went away."

Added Saxon: "The real hurting people are who Jesus would reach out to. That's our mission."

This story ran on page A01 of the Boston Globe on 08/23/99.

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Two Worlds Of HIV Care

Poor, Minorities Still Worse Off

By DAVID BROWN
Washington Post Staff Writer

Racial and socioeconomic disparities that mar the quality of medical care for people infected with the AIDS virus actually decreased after the arrival of $10,000-a-year "triple therapy" antiviral drugs three years ago.

Nevertheless, substantial differences in treatment for the human immunodeficiency virus (HIV) still exist, with white men infected through homosexual intercourse likely to get the best care, as gauged by several key measures.

Those are among the findings of a massive, government-financed survey of HIV treatment in the United States published today in the Journal of the American Medical Association.

"Clearly, there has been some improvement over time in access to care for people with HIV," said Martin F. Shapiro, a physician at the University of California at Los Angeles and at the Rand Corp., a research firm in Santa Monica, Calif., who was one of the leaders of the study. "The gaps between some groups did narrow over time, but they're still there."

The study found virtually no difference in quality of care between people with private insurance and those covered by health maintenance organizations (HMOs). However, the stability and quality of care of patients covered by Medicaid—the state and federal insurance program for the poor and disabled—more closely resembled that of the uninsured than the privately insured, the researchers found. Sex and education were among the strongest predictors of adequate HIV treatment, with men and college graduates faring better than women and people who didn't graduate from high school.

Between 650,000 and 900,000 Americans are infected with HIV, though about 275,000 are unaware of their infection. The HIV Cost and Services Utilization Study questioned nearly 3,000 people, randomly selected from 28 urban and 24 rural areas, who went to the doctor in the first two months of 1996. They were interviewed three times over three years.

The study began just as drugs in the "protease inhibitor" family of pharmaceuticals were being introduced. The drugs have cut AIDS mortality in half and have restored thousands of chronically ill people to vigorous life. The researchers used six measures of quality and stability in medical care. They included going to the doctor regularly, staying out of the hospital, taking triple-therapy drugs and getting preventive medicine for a kind of pneumonia, called PCP, that often kills people with AIDS.

In the first year of the study, 59 percent of people had tried triple therapy. Three years later, 85 percent had. For blacks, the percentage increased from 44 to 80; for Hispanics, 56 to 84; and for whites, 68 to 88. For men, the percentage rose from 61 to 87; for women, 49 to 78. About 72 percent of people with private insurance were on the life-extending drugs sometime during the first year. By the third, this had risen to 91 percent.

In one of the more startling findings, the percentage of people with no insurance who were on triple therapy rose from 46 to 79 in three years. Presumably, the drugs, which often cost $10,000 a year, are paid for by the patients, charities, or state-run AIDS Drug Assistance Programs. Triple therapy by Medicaid patients rose from 53 percent to 81 percent.

Patients who got care through HMOs were more likely to get preventive treatment for PCP than patients treated privately, by Medicaid or by Medicare, or the uninsured. The main finding on that quality measure, however, was that the treatment was used only about 75 percent of the time it should be, regardless of where a person was treated.

The percentage of people whose care was good by all six indicators rose from 29 to 47 in three years. The percentage whose care was substandard or unstable in two or more indicators fell from 34 to 17.

The HIV Cost and Services Utilization Study is the first national, random-sample study evaluating quality of care for patients with a chronic illness. It cost $25 million, about $15 million of which was provided by the federal Agency for Health Care Policy and Research. The researchers hope to follow the surviving patients to see how their care, attitudes and health evolve.

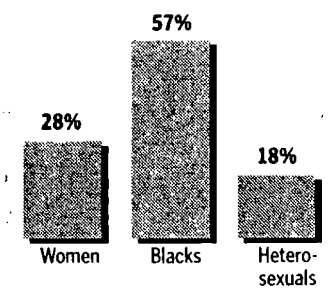
The Spread of AIDS

Here is the total number of AIDS cases reported by the end of 1998.

Race or ethnicity	Cases
White, non-Hispanic	304,094
Black, non-Hispanic	251,408
Hispanic	124,841
Asian/Pacific Islander	4,974
Native American	1,940
Unknown	943

The number of women, blacks and heterosexuals contracting HIV is growing rapidly.

Percentage of HIV diagnoses 1994-97



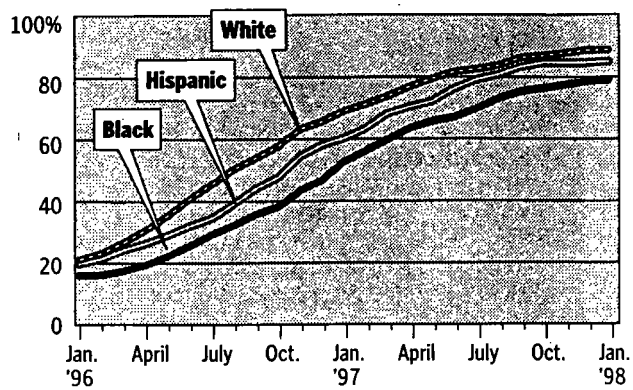
SOURCE: Centers for Disease Control and Prevention

THE WASHINGTON POST

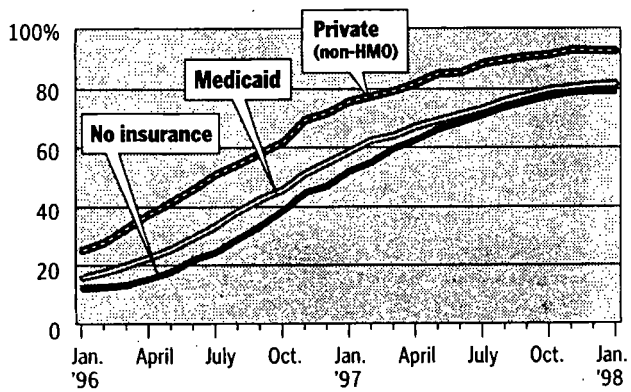
Disparate Treatment

Blacks and the uninsured were less likely to receive powerful AIDS drugs than other categories of HIV-infected patients who participated in a two-year study.

Receiving protease inhibitors, by race



Receiving protease inhibitors, by insurance type



SOURCE: Journal of the American Medical Association

THE WASHINGTON POST

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Kaiser Family Foundation

National Survey of African Americans on HIV/AIDS

Prepared for:

THE UNTOLD STORY: AIDS AND BLACK AMERICANS,
A Briefing on the Crisis of AIDS among African Americans

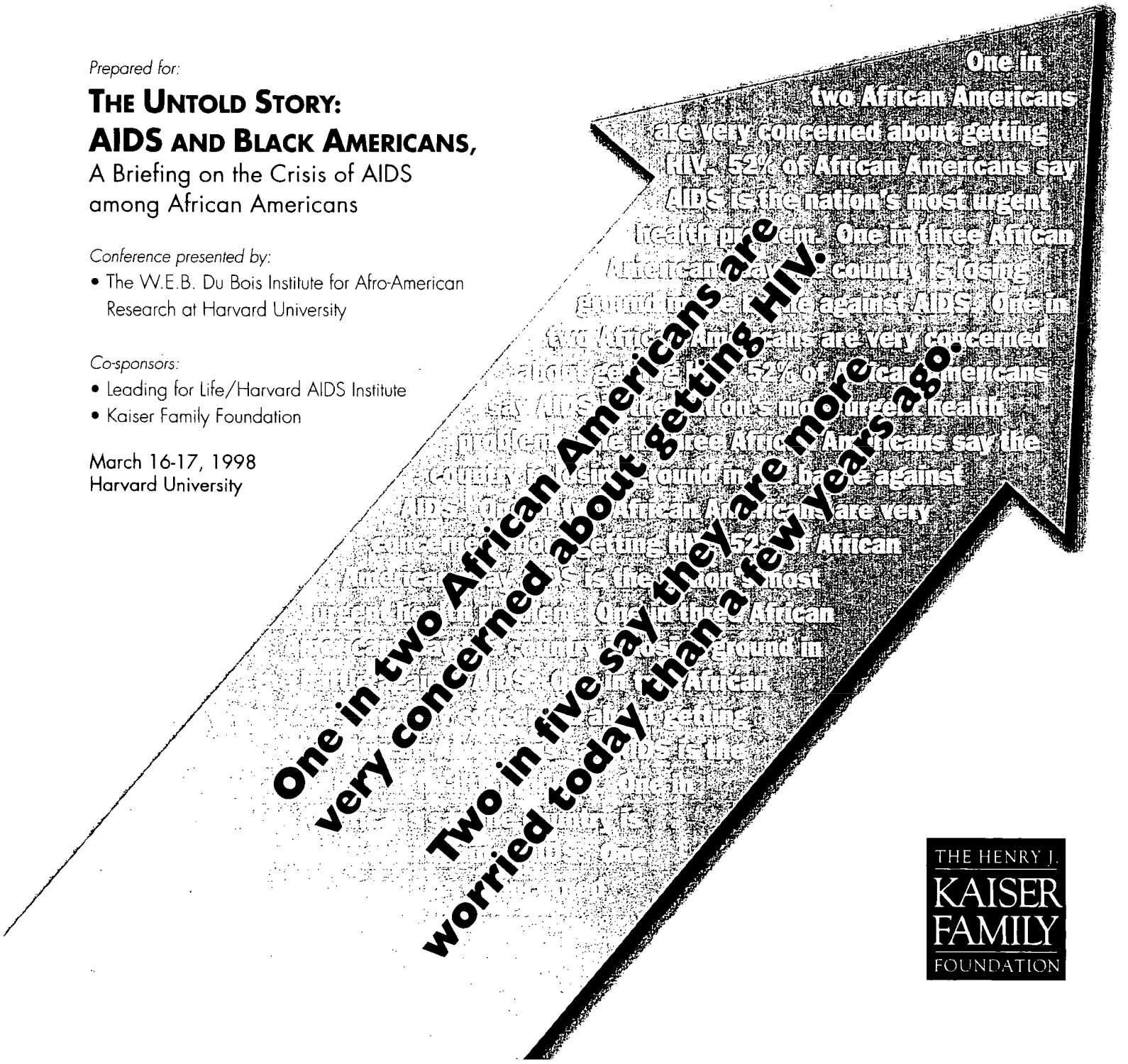
Conference presented by:

- The W.E.B. Du Bois Institute for Afro-American Research at Harvard University

Co-sponsors:

- Leading for Life/Harvard AIDS Institute
- Kaiser Family Foundation

March 16-17, 1998
Harvard University



THE HENRY J. KAISER FAMILY FOUNDATION

HIV/AIDS in the African-American Community

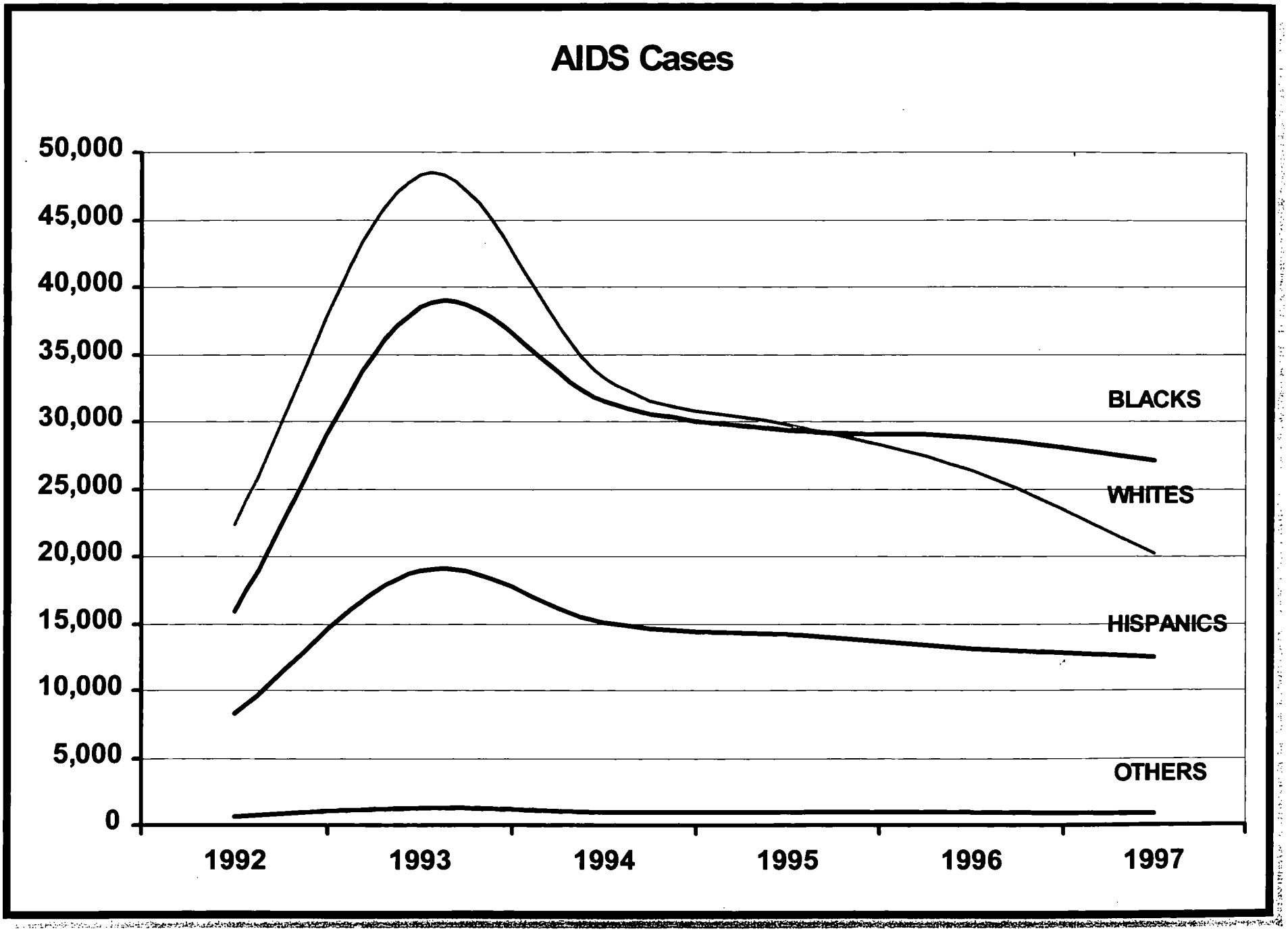
Southern Christian Leadership Conference

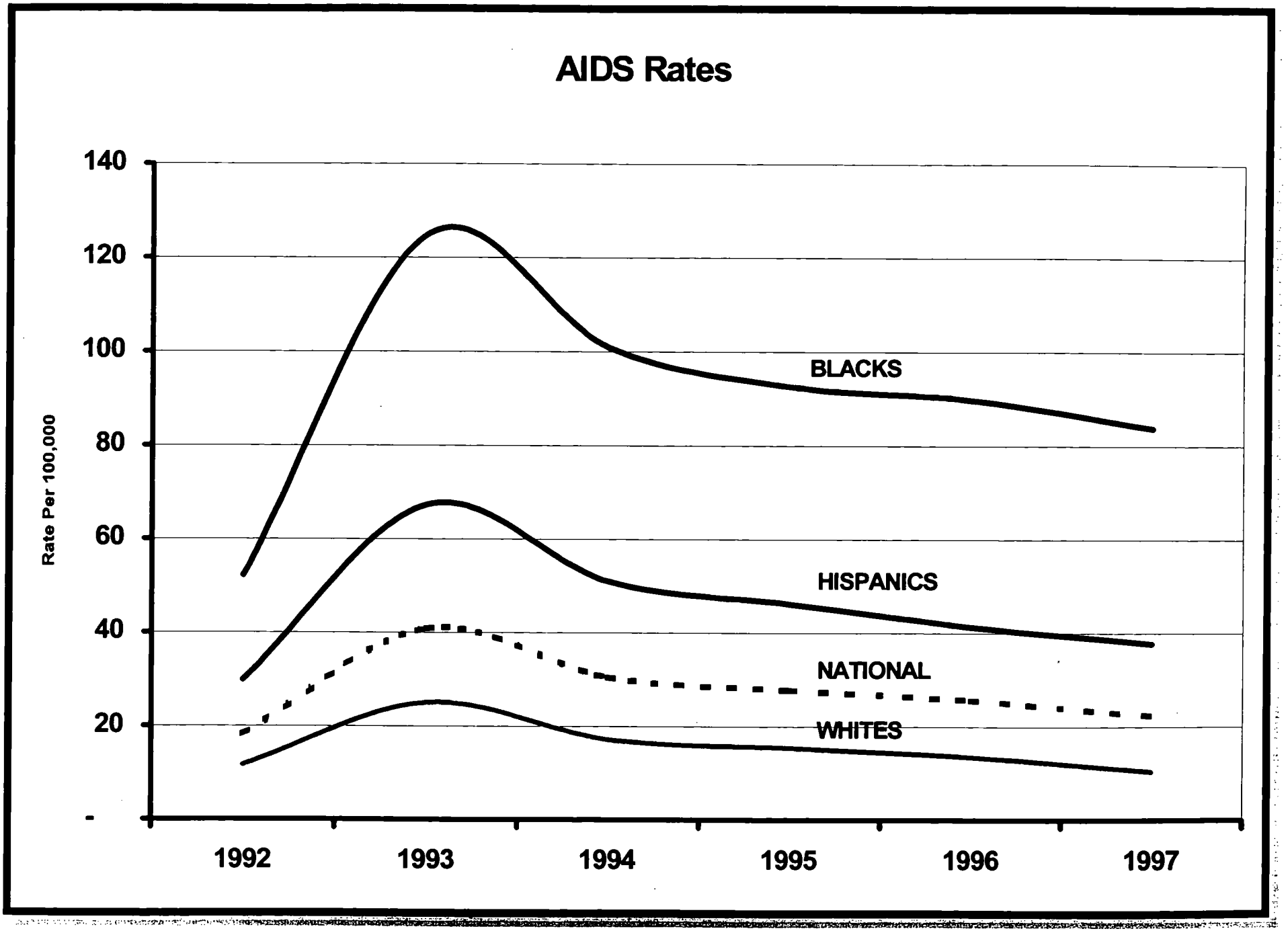
July 29, 1998

Sandra L. Thurman
Director
Office of National AIDS Policy

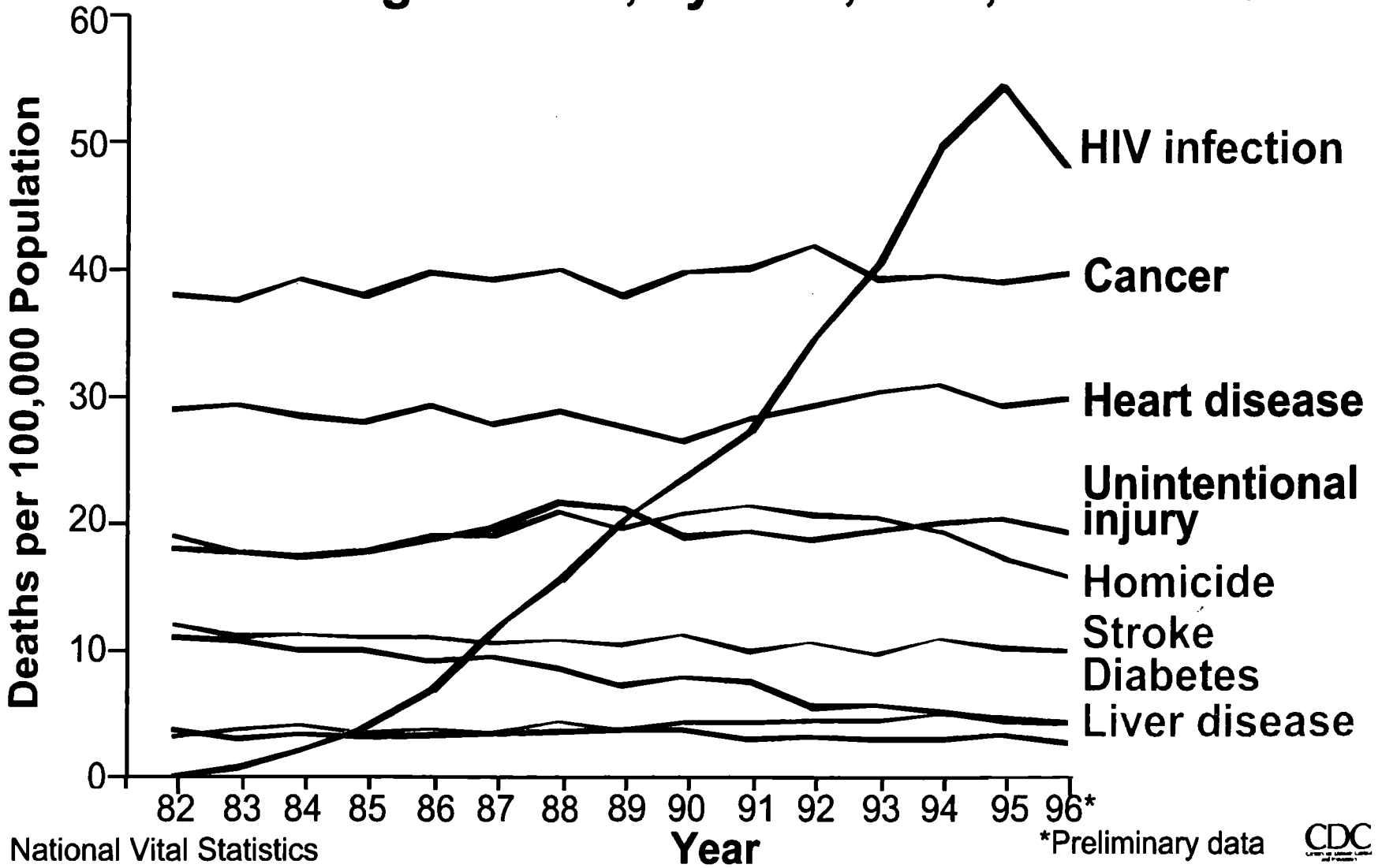
HIV/AIDS in the African-American Community

	New HIV Infections (1997)	Cumulative HIV Infections (thru 1997)	New AIDS Cases (1997)	Cumulative AIDS Cases (thru 1997)
Adults/ Adolescents	**57%**	**53%**	**45%**	**36%**
Men	**51%**	**48%**	**40%**	**32%**
Women	**70%**	**68%**	**60%**	**56%**
Pediatric	**71%**	**63%**	**62%**	**58%**

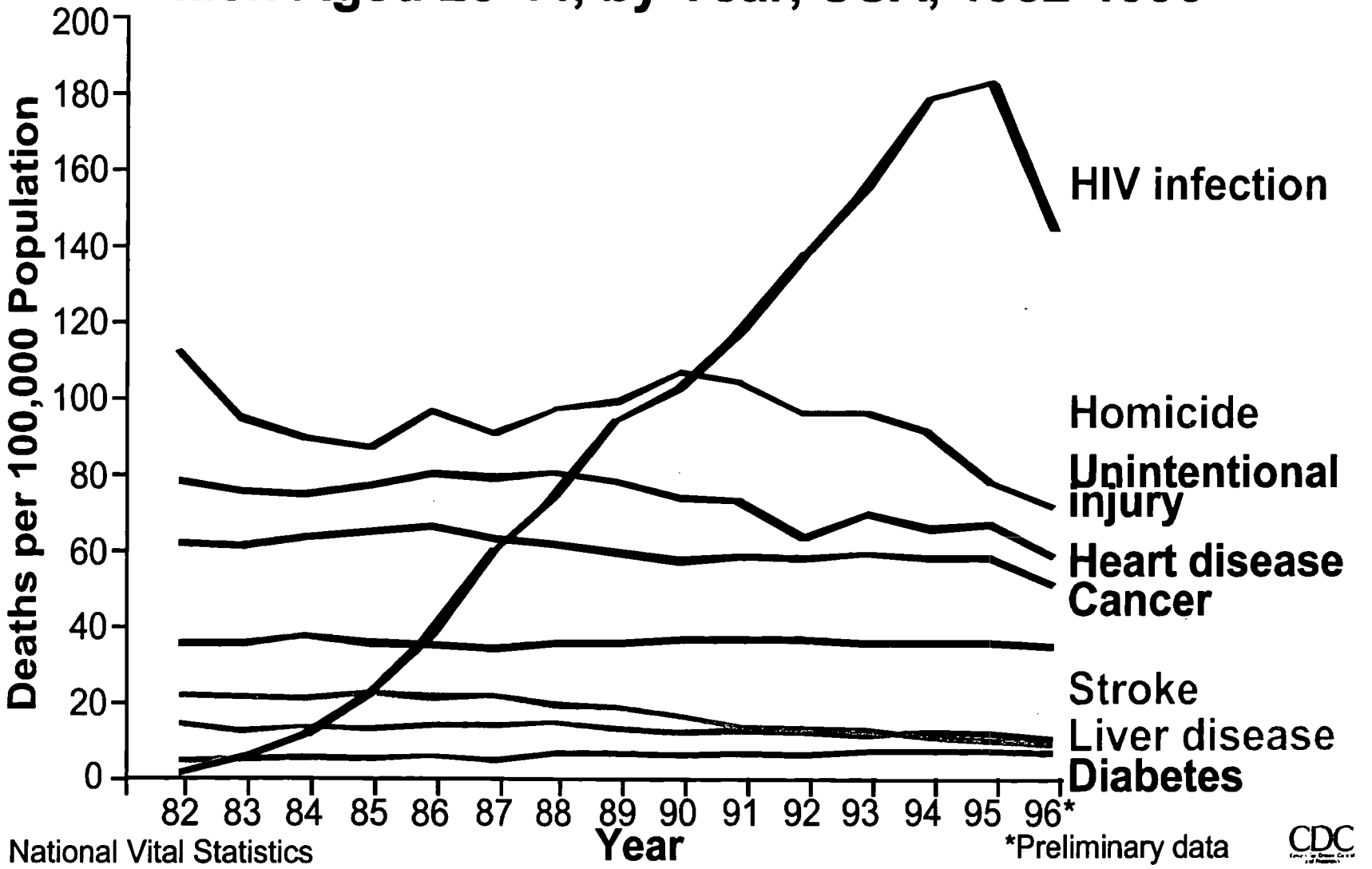

AIDS Cases
50,000
45,000
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
1992
1993
1994
1995
1996
1997
BLACKS
WHITES
HISPANICS
OTHERS


AIDS Rates
140
120
100
80
60
40
20
-
Rate Per 100,000
BLACKS
HISPANICS
NATIONAL
WHITES
1992
1993
1994
1995
1996
1997

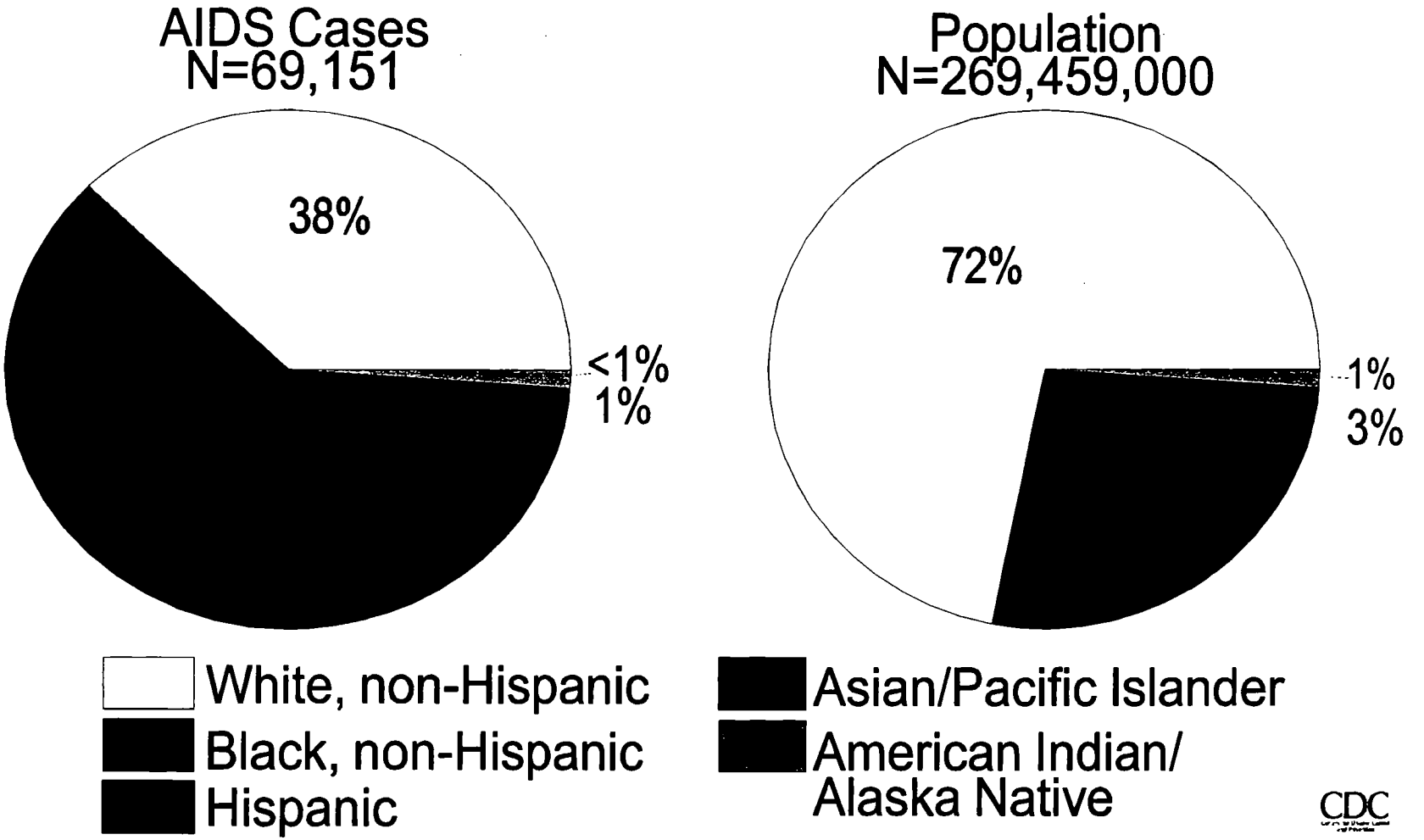
Death Rates from Leading Causes of Death in Black Women Aged 25-44, by Year, USA, 1982-1996



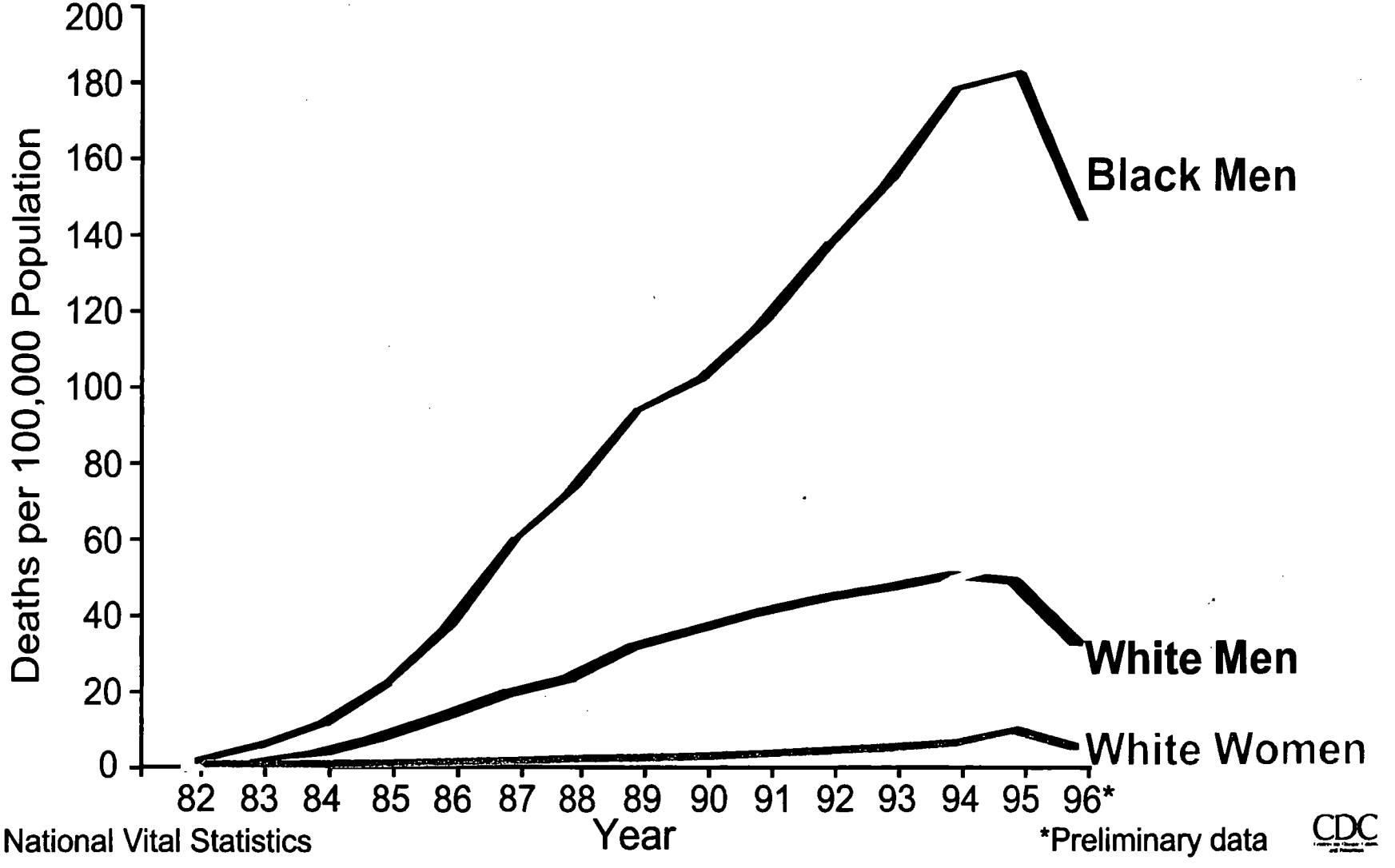
Death Rates from Leading Causes of Death in Black Men Aged 25-44, by Year, USA, 1982-1996



AIDS Cases Reported in 1996 and Estimated 1996 Population by Race/Ethnicity, United States



Death Rates from HIV Infection in Persons Aged 25-44 Years, By Sex, Race, and Year, 1982-1996 United States



National Vital Statistics

*Preliminary data

CDC

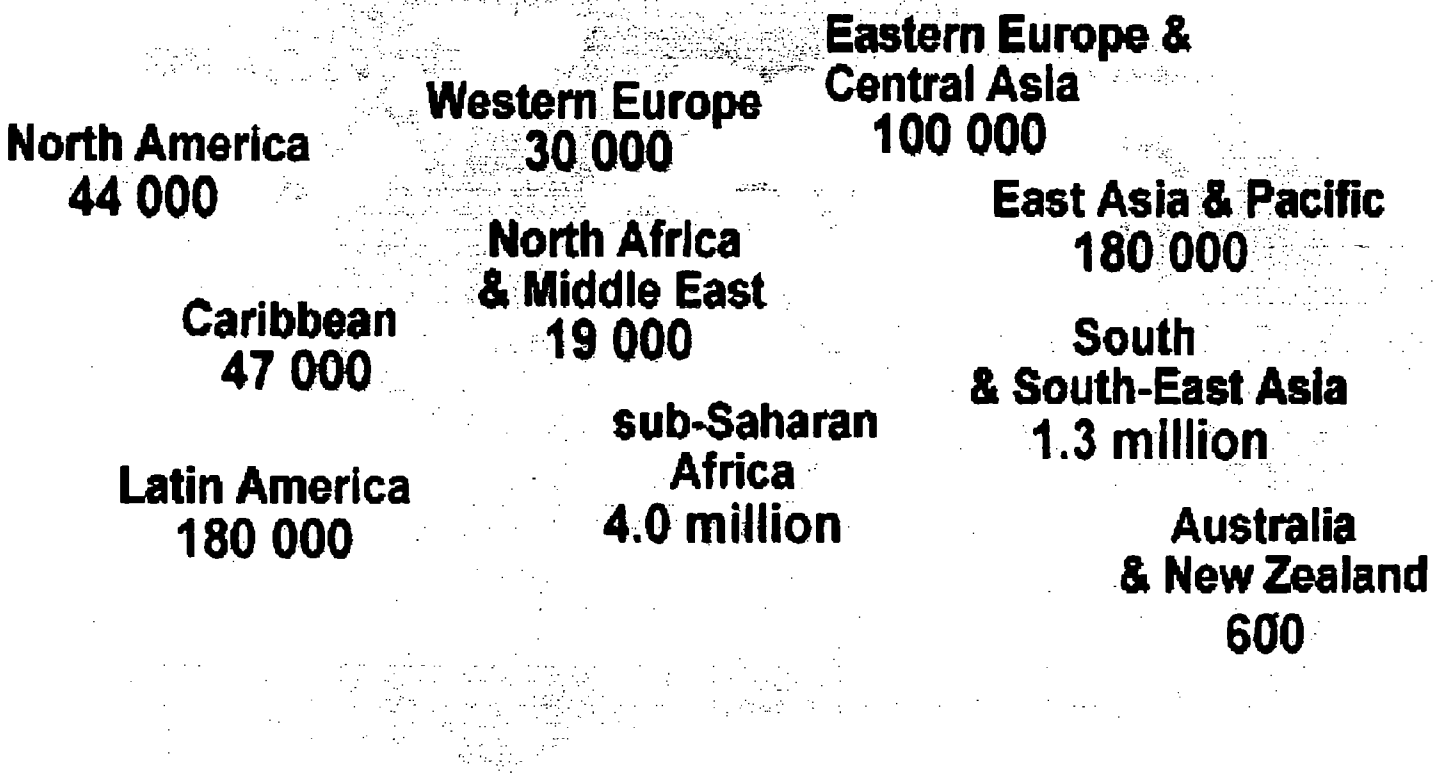
Kaiser Family Foundation Survey - 1996

How do African Americans rate local or community groups in the fight against AIDS?	**Rated as caring "a lot" about the fight against AIDS**	**Rated as doing "a lot" about the fight against AIDS**
Local health care providers (doctors, health clinics, hospitals)	**61%**	**40%**
Local public schools	**49%**	**28%**
Local church or religious leaders	**54%**	**23%**
And governments?		
Local government and political leaders	**17%**	**14%**
State government	**20%**	**17%**
Federal government	**22%**	**18%**

End-1997 global estimates

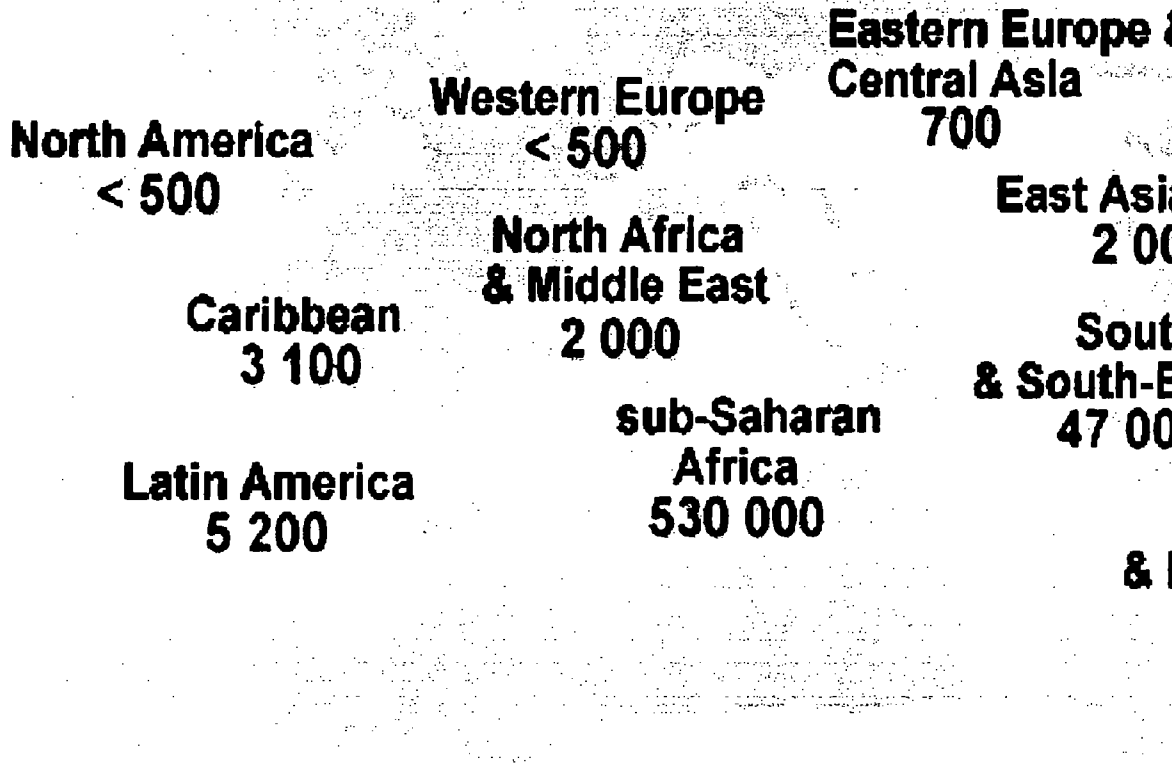
People living with HIV/AIDS	30.8 million
New HIV infections in 1997	5.8 million
Deaths due to HIV/AIDS in 1997	2.3 million
Cumulative number of deaths due to HIV/AIDS	11.7 million

Adult & Child New Infections - 1997



Source: UNAIDS

Children (<15) Infected in 1997



Source: UNAIDS

Adult & Child Deaths - 1997

North America
29 000

Western Europe
15 000

Eastern Europe &
Central Asia
300

East Asia & Pacific
6 200

North Africa
& Middle East
13 000

Caribbean
19 000

South
& South-East Asia
250 000

sub-Saharan
Africa
1.8 million

Latin America
81 000

Australia
& New Zealand
700

Source: UNAIDS

The African American Experience with HIV and Substance Abuse April 9th and 10th 1998

hosted by:
Communities of Color Outreach (COCO)
116 Roxbury St. ◆ Roxbury, MA 02119
617 - 427- 8192
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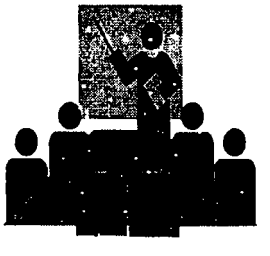

The African American Experience with HIV and Substance Abuse
April 9th and 10th 1998
hosted by: Communities of Color Outreach (COCO)

Goals & Objectives April 9, 1998

by the end of session participants will able to:

- identify specific aspects of drug addiction which require a knowledge and understanding of the African American condition
- demonstrate insight related to drug availability and drug abuse in lower socioeconomic communities, particularly those with populations of African decent
- recognize the importance of a working knowledge of Black history as a conduit for behavior change among Black clients
- explore those personal biases which create barriers to effective outreach and intervention efforts
- conduct and demonstrate newly acquired counseling skills, resulting from insights presented during the session

Agenda April 9, 1998

9:00	-	10:00	Introduction Overview
10:00	-	11:00	Addiction in the Black Community
11:00	-	11:15	Break
11:15	-	12:15	Black History Lost Stolen or a Stray
12:30	-	1:30	LUNCH
1:30	-	2:30	Drug Related HIV Prevention in a Culturally Specific Format
2:30	-	3:30	Barriers to effective HIV Education and Prevention Self Sabotage and other Destructive Forces
3:30	-	4:30	Debrief ◆ Discussion ◆ Action

The African American Experience with HIV and Substance Abuse
April 9th and 10th 1998
hosted by: Communities of Color Outreach (COCO)

Goals and Objectives April 10, 1998

by the end of the session participants will be able to:

- identify circumstances and situations which increase the likelihood that drugs will be available and used excessively in socioeconomic depressed urban communities
- discuss HIV prevention strategies which would assist drug users to avoid HIV contagion and transmission
- critically analyze the value of specific pharmacological treatments used to assist drug users
- identify at least three required actions which will improve education and prevention efforts in Black communities

Agenda April 10, 1998

9:00 -	9:45	Introduction and Recap
9:45 -	11:00	Educating and Advocating: critical thinking, talking points video: the Bottom Line
11:00 -	11:15	Break
11:15 -	12:00	Discussion: identification and utilization of alternative methods to treat chemically addicted clients
2:00 -	12:45	Taking Drug Users Seriously
1:00 -	2:00	Lunch
2:00 -	2:45	Practical Applications
2:45 -	3:30	Debrief ◆ Discussion ◆ Action

THERE WILL BE A FOLLOW UP SESSION ON JUNE 3RD AT THE COCO CENTER, 116 ROXBURY REGISTRATION IS REQUIRED

TOPIC: SKILL BUILDING: understanding and utilizing data and research to effectively serve communities.

What Puts People at Risk?

African Americans

Little information exists on risk factors specific to African-Americans, especially among IDUs, because until recently there has been a lack of research in this area. Structural barriers such as racism, homophobia, sexism, and low socioeconomic status and inadequate health care often complicate the picture for racial/ethnic minority people in the U.S.
African-Americans are often viewed as one group when there is a wide variety of populations in the US included under this heading, including upper class, lower class, Christian, Muslim, inner-city, suburban, descendants of slaves, and recent Caribbean immigrants. Current epidemiological surveillance does not capture or record the social, cultural, economic, geographic, religious, and political differences that may more accurately predict risk.

Injection drug use has played a major role in HIV infection among African-Americans. African-Americans are twice as likely as whites to have used drugs intravenously, and HIV infection is higher for black IDUs than white IDUs. One reason may be the concentration of blacks in inner-city areas where drug trafficking, unemployment and poverty, among other factors, have assured that blacks suffer high rates of addiction.

Although HIV transmission in African-American communities is primarily viewed as a problem among heterosexual IDUs and their sexual partners, the proportion of AIDS cases among African-Americans attributed to male homosexual/bisexual activity (36%) is almost equal to that attributed to injection drug use (38%).
In a survey of African American gay and bisexual men In the San Francisco Bay Area, more than 50% reported unprotected anal intercourse, a considerably higher percentage than among white gay men. Those men were more likely to be poor, to have been paid for sex, or to have used injection drugs; to engage in unprotected sex despite knowing risk of HIV infection; and to report less social support. Men with negative expectations and beliefs about condoms were less likely to use them.

Among homosexually active African-American men, including those who self-identify as gay, fear of homophobia and strong attachment to the minority community may have been strong disincentives to respond to AIDS as a primarily gay issue. At the beginning of the epidemic, the absence of national gay leaders and large gay constituencies in the African-American population offered few opportunities to mobilize support.

Having a larger number of sexual partners increases the risk of exposure to HIV. Among African American adults living in cities with a high prevalence of AIDS cases, almost one-fifth (19%) reported having two or more sexual partners in the past year. More men (30%) than women (10%) reported multiple partners. Substantial proportions of blacks with multiple sex partners used no condoms with either their main (47%) or secondary partners (35%).

Many members of racial/ethnic minority communities in the U.S. have held an underlying distrust of the white public health world, given the awareness of past abuses such as the Tuskeegee Syphilis Study with African-Americans, and the intentional spread of smallpox among Native people. Some groups, including African-Americans, believe that the effects of AIDS on the community are the results of deliberate efforts of the U.S. government. Adding to this are persistent inadequacies in social benefits, health care, education and opportunities for African-Americans.

Reference: HIV Prevention Fact Sheet:

HIGHLIGHTS

This report presents the first results from the 1996 National Household Survey on Drug Abuse, an annual survey conducted by SAMHSA. The survey provides estimates of the prevalence of use of a variety of illicit drugs, alcohol, and tobacco, based on a nationally representative sample of the civilian noninstitutionalized population age 12 years and older. In 1996, a sample of 18,269 persons was interviewed for the survey. Selected findings are given below:

Illicit Drug Use

•In 1996, an estimated 13.0 million Americans were current illicit drug users, meaning they had used an illicit drug in the month prior to interview. This represents no change from 1995 when the estimate was 12.8 million. The number of current illicit drug users was at its highest level in 1979 when there were 25 million.
•Following a significant increase from 1992 to 1995, between 1995 and 1996 there was a decrease in the rate of past month illicit drug use among youths age 12-17. The rate was 5.3 percent in 1992, 10.9 percent in 1995, and 9.0 percent in 1996. The decrease between 1995 and 1996 occurred in the younger part of this age group, i.e., those age 12 to 15 years.
•For those age 18-25 years, the rate of past month illicit drug use increased from 13.3 percent in 1994 to 15.6 percent in 1996. The rate of past month cocaine use also increased in this age group during this period, from 1.2 percent to 2.0 percent.
•There were an estimated 2.4 million people who started using marijuana in 1995. This was about the same number as in 1994. The annual number of marijuana initiates rose between 1991 and 1994.
•The rate of past month hallucinogen use among youths age 12-17 increased from 1.1 percent in 1994 to 2.0 percent in 1996.
•The overall number of current cocaine users did not change significantly between 1995 and 1996 (1.45 million in 1995 and 1.75 million in 1996). This is down from a peak of 5.7

million in 1985. Nevertheless, there were still an estimated 652,000 Americans who used cocaine for the first time in 1995.
•There were an estimated 141,000 new heroin users in 1995, and there has been an increasing trend in new heroin use since 1992. A large proportion of these recent new users were smoking, snorting, or sniffing heroin, and most were under age 26. The estimated number of past month heroin users increased from 68,000 in 1993 to 216,000 in 1996.

Alcohol Use

•In 1996, 109 million Americans age 12 and older had used alcohol in the past month (51 percent of the population). About 32 million engaged in binge drinking (5 or more drinks on at least one occasion in the past month) and about 11 million were heavy drinkers (drinking five or more drinks per occasion on 5 or more days in the past 30 days).
•About 9 million current drinkers were age 12-20 in 1996. Of these, 4.4 million were binge drinkers, including 1.9 million heavy drinkers.

Cigarette Use

•An estimated 62 million Americans were current smokers in 1996. This represents a smoking rate of 29 percent. Current cigarette smoking did not change between 1995 and 1996.
•Among youths age 12-17, rates of smoking did not change between 1995 and 1996. An estimated 18 percent of youths age 12-17 (4.1 million adolescents) were current smokers in 1996.
•In 1995, about 1.7 million Americans first became daily smokers. The estimated number of new smokers per year has remained relatively steady since the 1980's.

Perceived Risk and Availability of Drugs

•The percent of youths age 12-17 that perceived great risk in using marijuana once a month decreased from 1990 (40 percent) to 1994 (33 percent), but remained level from 1994 to 1996.
•The percent of youths reporting great risk in using cocaine once a month decreased from 63 percent in 1994 to 54 percent in 1996.
•The percent of youths reporting great risk in having five or more drinks once or twice a week decreased from 58 percent in 1992 to 45 percent in 1996. During that same period, the percent reporting great risk in having four or five drinks nearly every day increased from 61 percent to 67 percent.
•More than half of youths age 12-17 reported that marijuana was easy to obtain in 1996, and about one quarter reported that heroin was easy to obtain. Fifteen percent of youths reported being approached by someone selling drugs in the month prior to interview.

What Are African-Americans' HIV Prevention Needs?

Are African-American populations at risk?

Many African-American populations are at high risk for HIV infection, not because of their race or ethnicity, but because of the risk behaviors they may engage in. As with any population, it's not who you are, but what you do that puts you at risk for HIV. African-Americans are disproportionately affected by HIV: they account for 33% of total AIDS cases in the US, while comprising only 11% of the US population.

In 1994, more than half (57%) of AIDS cases among women were among African-Americans. Likewise, African-Americans accounted for over half of all AIDS cases among injection drug users (IDUs). In 1994, 62% of all children with AIDS were African-American.

Who are African-Americans at risk?

While African-Americans are often viewed as one group, there is, in fact, a wide variety of populations in the US included under this heading. **Error! Bookmark not defined.** Upper class, lower class, Christian, Muslim, inner-city, suburban, descendants of slaves and recent Caribbean immigrants all come under the African-American heading. Current epidemiological surveillance does not record these social, cultural, economic, geographic, religious, and political differences that may more accurately predict risk.

Although HIV transmission in African-American communities is primarily viewed as a problem among heterosexual IDUs and their sexual partners, the proportion of AIDS cases among African-Americans attributed to male homosexual/bisexual activity (36%) is almost equal to that attributed to injection drug use (38%).

Injection drug use has played a major role in HIV infection among African-Americans. African-Americans are twice as likely as whites to have used drugs intravenously, and HIV infection is higher for black IDUs than white IDUs One reason may be the "ghettoization" of blacks in inner-city areas where drug trafficking, unemployment and poverty, among other factors, have assured that blacks suffer high rates of addiction. Studies of drug users that describe significant association between health and race may be better explained by these characteristics of the social environment.

What puts African-Americans at risk?

Very little information exists on risk factors specific to African-Americans, especially among IDUs, because until recently there has been a lack of research in this area. Funding agencies have not targeted African-Americans as a particular area of concern for research. Few non-minority

researchers have demonstrated ongoing interest in intervention work with African-Americans, and currently less than 3% of National Institute of Health research grants are awarded to African-American researchers.
In a survey of African-American gay and bisexual men in the San Francisco Bay Area, more than 50% reported unprotected anal intercourse, a considerably higher percentage than among white gay men. Those men were more likely to be poor, to have been paid for sex, or to have used injection drugs; to engage in unprotected sex despite knowing risk of HIV infection; and to report less social support. Men with negative expectations and beliefs about condoms were less likely to use them

Among African-American adults living in cities with a high prevalence of AIDS cases, almost one-fifth (19%) reported having two or more sexual partners in the past year. More men (30%) than women (10%) reported multiple partners. Substantial proportions of blacks with multiple sex partners used no condoms with either their main (47%) or secondary partners (35%).

What are obstacles to prevention?

Many members of the black community have held an underlying distrust of the white public health world, especially since the Tuskegee Syphilis Study. Some groups, including some African-Americans, believe that the effects of AIDS on the community are the results of deliberate efforts of the US government. Adding to this are persistent inadequacies in social benefits, health care, education and opportunities for African-Americans. Effective prevention programs must address these concerns.
Among homosexually active African-American men, including those who self-identify as gay, fear of homophobia and strong attachment to the minority community may have been strong disincentives to respond to AIDS as a primarily gay issue. At the beginning of the epidemic, the absence of national gay leaders and large gay constituencies in the African-American population offered few opportunities to mobilize support.

What's being done?

Not many prevention programs specific to African-Americans have been evaluated for effectiveness, but the number of programs is increasing and there are a few promising studies. An intervention aimed at African-American gay and bisexual men extensively pilot tested all materials including videos that depicted only black men and addressed issues related to the men's same-sex attitudes and behaviors addressed in their own words. Clients who participated in three weekly three hour group sessions greatly reduced (50%) their frequency of unprotected anal intercourse, and maintained the behavior change through an 18-month follow-up.
African-American male adolescents in Philadelphia, PA took part in an intervention to increase knowledge of AIDS and sexually transmitted diseases (STDs) and weaken problematic attitudes towards risky sexual behaviors. Educational materials included a video narrated by a black woman with a multiethnic cast and "AIDS basketball" where teams earned points for correctly answering AIDS questions. Participants reported less sexual intercourse, fewer partners, and greater use of condoms after the intervention.
Men and women attending an STD clinic in the South Bronx, NY had access to either a video on condom use, or both the video and an interactive group session. Patients were given coupons for free condoms at a pharmacy several blocks from the clinic. Among African-American clients,

condom acquisition increased substantially after the video and group session, but not after the video alone. One reason may be that the video primarily targeted behavior change among men. Also, clients who self-identified as Caribbean had lived in the US for a shorter amount of time, and the video may have been embedded in US culture. This study showed that interactive sessions combined with videos can personalize the prevention message and enhance behavior change.

What needs to be done?

Researchers and service providers need a better understanding of the role of cultural and socioeconomic factors in the transmission of HIV, as well as the effect of racial inequality on public health. In addition, public health officials should consider changing epidemiological surveillance to include other demographic information besides sex, age and ethnicity. These efforts need to influence the design of prevention messages, services and programs.
In the second decade of the AIDS epidemic, few studies of HIV prevention interventions specifically for African-Americans have been conducted or published. **Error! Bookmark not defined.** Especially lacking are studies of African-American IDUs and gay/bisexual men. A comprehensive HIV prevention strategy uses many elements to protect as many people at risk for HIV as possible. Effective and equitable HIV research, policy, program and funding efforts are urgently needed in African-American communities.

Says who?

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Prepared by Pamela DeCarlo and John Peterson, PhD

The Tuskegee Syphilis Study: A Hard Lesson Learned

The Tuskegee Syphilis Study, carried out in Macon County, Alabama, from 1932 to 1972, is an example of medical research gone wrong. The United States Public Health Service, in trying to learn more about syphilis and justify treatment programs for blacks, withheld adequate treatment from a group of poor black men who had the disease, causing needless pain and suffering for the men and their loved ones. In the wake of the Tuskegee Study and other studies, government took a closer look at research involving human subjects and made changes to prevent the moral breaches that occurred in Tuskegee from happening again.

The Study Begins

In 1932, the Public Health Service, working with the Tuskegee Institute, began a study in Macon County, Alabama, to record the natural history of syphilis in hopes of justifying treatment programs for blacks. It was called the "Tuskegee Study of Untreated Syphilis in the Negro Male".
The study involved 600 black men—399 with syphilis and 201 who did not have the disease. Researchers told the men they were being treated for "bad blood," a local term used to describe several ailments, including syphilis, anemia, and fatigue. In truth, they did not receive the proper treatment needed to cure their illness. In exchange for taking part in the study, the men received free medical exams, free meals, and burial insurance. Although originally projected to last 6 months, the study actually went on for 40 years.

What Went Wrong?

In July 1972, a front-page *New York Times* story about the Tuskegee Study caused a public outcry that led the Assistant Secretary for Health and Scientific Affairs to appoint an Ad Hoc Advisory Panel to review the study. The panel had nine members from the fields of medicine, law, religion, labor, education, health administration, and public affairs.
The panel found that the men had agreed freely to be examined and treated. However, there was no evidence that researchers had informed them of the study or its real purpose. In fact, the men had been misled and had not been given all the facts required to provide informed consent.
The men were never given adequate treatment for their disease. Even when penicillin became the drug of choice for syphilis in 1947, researchers did not offer it to the subjects. The advisory panel found nothing to show that subjects were ever given the choice of quitting the study, even when this new, highly effective treatment became widely used.

The Study Ends and Reparation Begins

The advisory panel concluded that the Tuskegee Study was "ethically unjustified"—the knowledge gained was sparse when compared with the risks the study posed for its subjects. In October 1972, the panel advised stopping the study at once. A month later, the Assistant Secretary for Health and Scientific Affairs announced the end of the Tuskegee Study.

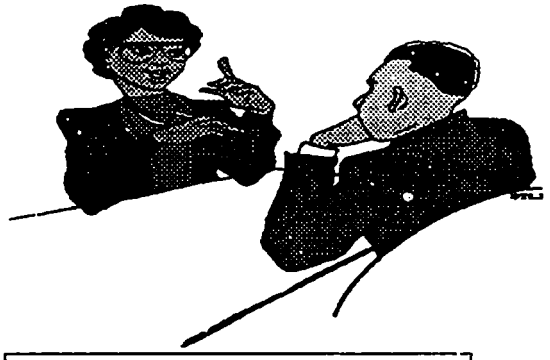
In the summer of 1973, a class-action lawsuit filed by the National Association for the Advancement of Colored People (NAACP) ended in a settlement that gave more than $9 million to the study participants. As part of the settlement, the U.S. government promised to give free medical and burial services to all living participants. The Tuskegee Health Benefit Program was established to provide these services. It also gave health services for wives, widows, and children who had been infected because of the study. The Centers for Disease Control and Prevention was given responsibility for the program, where it remains today in the

After the Tuskegee Study, the government changed its research practices to prevent a repeat of the mistakes made in Tuskegee.

In 1974, the National Research Act was signed into law, creating the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. The group identified basic principles of research conduct and suggested ways to ensure those principles were followed.
In addition to the panel's recommendations, regulations were passed in 1974 that required researchers to get voluntary informed consent from all persons taking part in studies done or funded by the Department of Health, Education, and Welfare (DHEW). They also required that all DHEW-supported studies using human subjects be reviewed by Institutional Review Boards, which read study protocols and decide whether they meet ethical standards.

The rules and policies for human subjects research have been reviewed and revised many times since they were first approved. From 1980–1983, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research looked at federal rules for doing research on human subjects to see how well those rules were being followed. An Ethics Advisory Board was formed in the late 1970s to review ethical issues of biomedical research. In 1991, federal departments and agencies (16 total) adopted the Federal Policy for the Protection of Human Subjects.

Efforts to promote the highest ethical standards in research are still going on today. In October 1995, President Bill Clinton created a National Bioethics Advisory Commission, funded and led by the Department of Health and Human Services. The commission is reviewing current regulations, policies, and procedures to ensure all possible safeguards are in place to protect research volunteers.



Work with a partner to arrive at Consensus !

Identify areas where you both are deadlocked.

Decide which one of you will give a report to the entire group.

LEVELS OF RISK

- Define the concept of risk ?
- How do you determine risk ?
- How do you determine a reasonable risk ?

1.0 personal vulnerability
1.1 family impact
1.2 societal norms

- How important is it that other people accept your decisions about risk ?
- Identify three risky behaviors that you have grown accustomed to :

a) name the behavior
b) identify a purpose the behavior has in your life
c) describe actions or conditions which reduce the "risks" involved
d) justify future usage of the discussed risk behavior !

HARM REDUCTION

'The harm reduction model upholds that abstinence is the ideal goal for those using illegal drugs. Abstinence from drugs reduces drug-related harm completely. It is hoped that all individuals who use illicit substances will eventually come to give themup entirely. Proponents of Harm Reduction recognize, however, that there will always be illicit drug use (unless we can successfully eliminate every psychoactive plant and synthetic relative from the face of the planet) and that many people are simply unwilling or unable to give up drugs entirely but nonetheless could benefit from intervention...

To provide services from a harm reduction perspective involves accepting that some people simply are not going to give up drugs at this time. Offering them services nonetheless, opens the door to helping people reduce harm in some way—even an infinitesimal way—that wouldn't otherwise occur.

Small reductions of harm are better than no reduction (and definitely better than exacerbation). An open door policy can result in a harm reduction snowball effect: small improvement can pave the path for further reduction of drug use and an improved lifestyle in other ways. This snowball effect can continue, eventually to the point of abstinence.'

(adapted from)

Robert Westermeyer, Ph.D.,

'Harm Reduction and Illicit Drug Use',

http://www.cts.com/~habtsmrt/drugs.html

THE DUTCH APPROACH

'Dutch drug policy aims to maintain a separation between the market for soft drugs (cannabis products such as hashish and marijuana) and the market for harder substances (such as heroin and cocaine). This is effectuated by allowing some limited freedom of movement for the retail trade and the possession of small quantities of soft drugs for individual consumption, and by trying to combat the hard drug trade in every possible way...

'Penal provisions for soft drug delicts are considerably milder than those for hard drugs. Moreover, a distinction is made between drug users and traffickers. The (border-crossing) drug trade

has a high priority and great efforts are made to keep users out of the illegal circuit. Possession of soft drugs and hard drugs for commercial purposes is therefore considered a more serious offence than possession for individual consumption...

'Over the years the above mentioned legislation has lead to the establishment of the so-called coffee shops where trading in soft drugs on certain conditions is not prosecuted. Trade in hard drugs, however, is strictly prohibited. Thus the cannabis consumer is not dependent on multi-drug markets which reduces the risk of switching to harder substances...

'The majority of the coffee shops adheres to nation-wide criteria ('Regulations'). The closing down of a number of coffee shops and a more rigid police control in recent years have shown that these criteria are strictly maintained...

'Prevention, information and education are a primary concern of the Dutch drug policy. In 1991 the project 'Healthy schools and stimulants' was launched, specifically aiming at the Secondary School students. The project is carried out in cooperation with the Netherlands Institute for Alcohol and Drugs, the local and provincial Public Health Services and the municipalities. The project provides information on subsequently tobacco, alcohol, cannabis and gambling for Secondary School students of an age when they generally have their first contacts with these items.'

Netherlands Institute for Alcohol and Drugs (NIAD),

Dutch Cannabis Policy Fact sheet,

http://www.niad.nl/fc1uk.htm

Decriminalization_ - As the word itself indicates, decriminalization involves freeing the drug user/possessor from criminal status, and limits the punishment for drug possession (under a certain amount) to a citation and minimal fine. As passed in eleven U.S. states (Alaska, Oregon, Colorado, California, New York, Nebraska, Maine, Mississippi, Ohio, Minnesota, and

North Carolina), decriminalization maintains the felony status of cultivating, distributing, and trafficking marijuana, but eliminates the incarceration of possessors of small amounts of drug for personal use.'

NASRO Issue Brief, Spring 1995 vol. 1, no.1,

'Rethinking the War on Drugs and Crime: New Approaches to Local Policy'.

http://www.dscc.org/cwa/report.html

Study Finds Aid Outdoes '3 Strikes' in Crime Fight Prevention: Rand Corp. says cash graduation incentives and parent training are more cost-effective.

By Carla Rivera, Los Angeles Times

[paraphrased]

A program that offers youths cash and scholarships to stay in high school averted five times as many serious crimes as California's "three strikes" law, according to an analysis that for the first time attempts to measure the cost-effectiveness of social programs aimed at reducing youth crime.
The study released this week by the Rand Corp. found that for each dollar spent, the graduation incentives and intervention programs that monitored high school delinquents and targeted parents of high-risk youth for training were far more effective at stemming crime than simply incarcerating people who already have committed crimes.

A previous Rand study estimated that the "three strikes" law might reduce serious crime by 21%, but at a cost of $5.5 billion per year. The new study indicates that a combination of the graduation incentives and parent training could cut crime just as much for less than $1 billion.

The authors of the study caution that the new findings are based on a limited number of pilot projects scattered around the country and concede that their analysis employs long-range projections of who is likely to commit crimes, and sometimes makes "educated guesses." But they contend that the data are persuasive enough to warrant spending money for larger-scale demonstrations.
"None of this suggests that incarceration is the wrong approach, but the question is: Do you want to devote all the money for solving these problems to that one approach?" said the study's principal author, Peter W. Greenwood.
The new study is unique because it attempts for the first time to quantify theories about the benefits of social welfare programs.

"The new wrinkle is that it pits treatment programs in head-to-head competition with punishment programs, making assumptions about effectiveness of each--in other words how much bang you will get from modestly effective treatment versus building X number of new jail cells. And it comes out with a relatively rosy-looking cost analysis," said Franklin E. Zimring, a professor of law and director of the Earl Warren Legal Institute at UC Berkeley.

Critics have contended that a previous Rand analysis of the "three strikes" legislation understated its cost savings. Greenwood said the new study is likely to be equally controversial given the politically charged debate on crime prevention.

And he conceded that budgetary constraints could hamper attempts to implement broad-scale social programs, even on a trial basis.
A spokesman for Gov. Pete Wilson said the study seemed to be weighing "apples and oranges" in its analysis of the most cost-effective crime programs.
"That having kids graduate from high school keeps them from committing crimes is stating the obvious," said Wilson aide Sean Walsh. "High school kids are not going to jail on the 'three strikes' law. We readily acknowledge that having a two-parent family and things like mentoring programs are valuable, and the state has proposed those. But it seems a lot gray matter and ink went into studying something that was readily apparent."

But other proponents of California's "three strikes" law cautiously supported the findings. "Prevention programs have a role, especially for young people, and we're supportive of that," said California Secretary of State Bill Jones. Jones is a former state assemblyman who co-authored the "three strikes" legislation.
"I think both approaches are appropriate, and I think Rand would agree. However, you cannot argue that we are spending too much money on incarceration or that you need to take away money for one program to fund the other."
A spokesman for California Atty. Gen. Dan Lungren echoed that support.

"Obviously prevention is important, but we have to have both," said Steve Telliano. "Prevention programs by themselves can't work without the threat of punishment."

The Rand study focused on four different types of early intervention program targeting the children of poor, single mothers. Research has shown that these children are at greater risk of engaging in criminal activities.
One group of programs involved home visits by counselors to help families resolve problems in child rearing, personal relations and community involvement, and provided day care. Follow-up studies of one such program sponsored by Syracuse University found that 6% of the experimental group ended up on probation compared with 22% of a matched control group. This program was found the least cost-effective.

The second type of program was aimed at parents already having trouble with their children and offered training in how to monitor their child's behavior and respond with appropriate rewards and punishments. Short-term evaluation of one of these programs showed that the training particularly reduces stealing and other anti-social behavior.

A third type of program offered intensive supervision and counseling of youngsters who have already begun to accumulate an arrest record. Analysis of one Orange County pilot project aimed at youth under 15 year of age and their families found that a combination of support services could reduce recidivism rates as much as 50%. This was found to be the third most effective way to reduce crime for the money spent.

The most successful approach studied by the Rand team provided cash and scholarships to keep youths in high school. The largest program in this group is an effort funded by the Ford Foundation and the U.S. Department of Labor that began as a pilot project in 1988. Student participants earn money for extracurricular academic studies, community activities and work.
Over a four-year period, students in the program could earn a maximum of $7,500 in stipends plus a matching amount in scholarship funds. The average was $2,300 in stipends and college money. But the incentives were found to significantly increase graduation rates and college enrollment. Seventy-three of the 100 young people in the initial project are still in college, said program director Ben Lattimore.

"The research suggested that 60% to 75% of these kids would not have finished high school, would have been involved in crimes, would be pregnant or substance abusers," said Lattimore. "I'm happy the Rand study paints a positive picture, but I personally think these programs are important no matter what the cost and can have a huge impact."

One graduate of the incentive program, 21-year-old Vincent Coleman, used the money to enroll at Indiana University of Pennsylvania and is now a sophomore majoring in accounting. Some of the friends he hung out with in the rough north Philadelphia neighborhood where he grew up are now in jail or dead. The incentive program probably turned his life around, he said.

"I'd probably be right there myself," said Coleman, who has returned to the program to help counsel a new crop of participants.

Payoffs of Crime Deterrents

Crime might be reduced more economically by programs that keep high-risk youth out of trouble than by longer prison sentences, according to an analysis by the Rand Corp. Here are comparative deterrent effects of four types of preventive programs and California's "three strikes" law, expressed in serious crimes prevented per million dollars spent.

Home visits, day care: 11 crimes prevented
Delinquent supervision: 72 crimes prevented
Parent training: 157 crimes prevented
Graduation incentives: 258 crimes prevented
"Three strikes" law: 60 crimes

HIGHLIGHTS 1996

National Household Survey on Drug Abuse

This report presents the first results from the 1996 National Household Survey on Drug Abuse, an annual survey conducted by SAMHSA. The survey provides estimates of the prevalence of use of a variety of illicit drugs, alcohol, and tobacco, based on a nationally representative sample of the civilian non institutionalized population age 12 years and older. In 1996, a sample of 18,269 persons was interviewed for the survey. Selected findings are given below:

Illicit Drug Use

In 1996, an estimated 13.0 million Americans were current illicit drug users, meaning they had used an illicit drug in the month prior to interview. This represents no change from 1995 when the estimate was 12.8 million. The number of current illicit drug users was at its highest level in 1979 when there were 25 million.

Following a significant increase from 1992 to 1995, between 1995 and 1996 there was a decrease in the rate of past month illicit drug use among youths age 12-17. The rate was 5.3 percent in 1992, 10.9 percent in 1995, and 9.0 percent in 1996. The decrease between 1995 and 1996 occurred in the younger part of this age group, i.e., those age 12 to 15 years. For those age 18-25 years, the rate of past month illicit drug use increased from 13.3 percent in 1994 to 15.6 percent in 1996. The rate of past month cocaine use also increased in this age group during this period, from 1.2 percent to 2.0 percent.
There were an estimated 2.4 million people who started using marijuana in 1995. This was about the same number as in 1994. The annual number of marijuana initiates rose between 1991 and 1994.

The rate of past month hallucinogen use among youths age 12-17 increased from 1.1 percent in 1994 to 2.0 percent in 1996.

The overall number of current cocaine users did not change significantly between 1995 and 1996 (1.45 million in 1995 and 1.75 million in 1996). This is down from a peak of 5.7 million in 1985. Nevertheless, there were still an estimated 652,000 Americans who used cocaine for the first time in 1995.

There were an estimated 141,000 new heroin users in 1995, and there has been an increasing trend in new heroin use since 1992. A large proportion of these recent new users were smoking, snorting, or sniffing heroin, and most were under age 26. The estimated number of past month heroin users increased from 68,000 in 1993 to 216,000 in 1996.

Alcohol Use

In 1996, 109 million Americans age 12 and older had used alcohol in the past month (51 percent of the population). About 32 million engaged in binge drinking (5 or more drinks on at least one occasion in the past month) and about 11 million were heavy drinkers (drinking five or more drinks per occasion on 5 or more days in the past 30 days).
About 9 million current drinkers were age 12-20 in 1996. Of these, 4.4 million were binge drinkers, including 1.9 million heavy drinkers.

Cigarette Use

An estimated 62 million Americans were current smokers in 1996. This represents a smoking rate of 29 percent. Current cigarette smoking did not change between 1995 and 1996.
Among youths age 12-17, rates of smoking did not change between 1995 and 1996. An estimated 18 percent of youths age 12-17 (4.1 million adolescents) were current smokers in 1996.

In 1995, about 1.7 million Americans first became daily smokers. The estimated number of new smokers per year has remained relatively steady since the 1980's.

Perceived Risk and Availability of Drugs

The percent of youths age 12-17 that perceived great risk in using marijuana once a month decreased from 1990 (40 percent) to 1994 (33 percent), but remained level from 1994 to 1996.
The percent of youths reporting great risk in using cocaine once a month decreased from 63 percent in 1994 to 54 percent in 1996.
The percent of youths reporting great risk in having five or more drinks once or twice a week decreased from 58 percent in 1992 to 45 percent in 1996. During that same period, the percent reporting great risk in having four or five drinks nearly every day increased from 61 percent to 67 percent.

More than half of youths age 12-17 reported that marijuana was easy to obtain in 1996, and about one quarter reported that heroin was easy to obtain. Fifteen percent of youths reported being approached by someone selling drugs in the month prior to interview.

Are Mandatory Minimum Drug Sentences Cost-Effective?

Mandatory minimum sentencing laws have been among the more popular crime-fighting measures of recent years. Such laws require that a judge impose a sentence of at least a specified length if certain criteria are met. For example, a person convicted by a federal court of possessing half a kilogram or more of cocaine powder must be sentenced to at least five years in prison.

Mandatory minimums have enjoyed strong bipartisan support. To proponents, their certainty and severity help ensure that incarceration's goals will be achieved. Those goals include punishing the convicted and keeping them from committing more crimes for a period of time, as well as deterring others not in prison from committing similar crimes. Critics, however, believe that mandatory minimums foreclose discretionary judgment where it may most be needed, and they fear these laws result in instances of unjust punishment.

These are all important considerations, but mandatory minimums associated with drug crimes may also be viewed as a means of achieving the nation's drug control objectives. As such, how do they compare with other means? Do they contribute to the central objective--decreasing the nation's drug consumption and related consequences--at a cost that compares favorably with other approaches? Jonathan P. Caulkins, C. Peter Rydell, William L. Schwabe, and James Chiesa have estimated how successful mandatory minimum sentences are, relative to other control strategies, at reducing drug consumption and drug-related crime.

The DPRC researchers focused on cocaine, which many view as the most problematic drug in America today. They took two approaches to mathematically model the market for cocaine and arrived at the same basic conclusion: *Mandatory minimum sentences are not justifiable on the basis of cost-effectiveness at reducing cocaine consumption or drug-related crime.* Mandatory minimums reduce cocaine consumption less per million taxpayer dollars spent than spending the same amount on enforcement under the previous sentencing regime. And either enforcement approach reduces drug consumption less, per million dollars spent, than putting heavy users through treatment programs. Mandatory minimums are also less cost-effective than either alternative at reducing cocaine-related crime. A principal reason for these findings is the high cost of incarceration.

Reducing Consumption: More Enforcement Against Typical Dealers

Caulkins, Rydell, and their colleagues first estimated the cost-effectiveness of additional expenditures on enforcement against the average drug dealer apprehended in the United States (whether that apprehension is by federal, state, or local authorities). Increased enforcement places additional costs on dealers, which they pass along to cocaine consumers in the form of higher prices. Studies have shown that higher cocaine prices discourage consumption. By mathematically modeling how cocaine market demand and supply respond to price, the researchers were able to estimate the changes in total cocaine consumption over 15 years for an additional million dollars invested in different cocaine control strategies.

Perhaps mandatory minimum sentences would be more cost-effective if they were applied only to higher-level dealers, who make more money and thus have more to lose from intensive enforcement. To approximate such a restriction, Caulkins and his colleagues limited the set of dealers analyzed to those prosecuted at the federal level who possess enough drugs to trigger a federal mandatory minimum sentence. Again, they analyzed how costs imposed on dealers influence cocaine market demand and supply.

Spending a million dollars on mandatory minimum sentences for higher-level dealers does indeed have a bigger effect on cocaine consumption than spending the same amount on either enforcement approach against typical dealers. Nonetheless, against any given type of dealer (or at any given level of government), mandatory minimums are less cost-effective than conventional enforcement. Moreover, although federal mandatory minimums do better relative to treating heavy users than do longer sentences for all dealers, treatment is still more cost-effective.

Why is conventional enforcement more cost-effective than mandatory minimums? Drug enforcement imposes costs on dealers through arrest and conviction, which includes seizure of drugs and other assets, and through incarceration, which involves loss of income. It turns out that, *per dollar spent,* the cost burden from seizures is greater. A million dollars spent extending sentences thus imposes less cost on dealers--and consequently reduces cocaine consumption less--than a million dollars spent on conventional enforcement, which includes asset seizures.

Reducing Cocaine-Related Crime

Many Americans are worried about the crime associated with cocaine production, distribution, and use. Working with data on the causes of drug-related crime, Caulkins and his colleagues estimated the crime reduction benefits of the various alternatives. They found no difference between conventional enforcement and mandatory minimums in relation to property crime. Conventional enforcement, however, should reduce crimes against persons by about 70 percent more than mandatory minimums. But treatment

should reduce serious crimes (against both property and persons) the most per million dollars spent--on the order of fifteen times as much as would the incarceration alternatives. Why is treatment so much better? Most drug-related crime is economically motivated--undertaken, for example, to procure money to support a habit or to settle scores between rival dealers. The level of economically motivated crime is related to the amount of money flowing through the cocaine market. When a treated dealer stays off drugs, that means less money flowing into the market--therefore, less crime. When a dealer facing greater enforcement pressure raises his price to compensate for the increased risk, buyers will reduce the amount of cocaine they purchase. Money flow equals price times quantity bought. Which effect predominates--the rise in price or the drop in consumption? The best evidence suggests that they cancel each other out, so the total revenue flowing through the cocaine market stays about the same. The effect of the enforcement alternatives is therefore limited almost entirely to the relatively small number of crimes that are the direct result of drug consumption--crimes "under the influence."

Conclusion

Long sentences for serious crimes have intuitive appeal. They respond to deeply held beliefs about punishment for evil actions, and in many cases they ensure that, by removing a criminal from the streets, further crimes that would have been committed will not be. But in the case of black-market crimes like drug dealing, a jailed supplier is often replaced by another supplier. Limited cocaine control resources can, however, be profitably directed toward other important objectives--reducing cocaine consumption and the violence and theft that accompany the cocaine market. If those are the goals, more can be achieved by spending additional money arresting, prosecuting, and sentencing dealers to standard prison terms than by spending it sentencing fewer dealers to longer, mandatory terms. The DPRC researchers found an exception in the case of the highest-level dealers, where sentences of mandatory minimum length appear to be the most cost-effective approach. However, it is difficult to identify those dealers solely by quantity of drug possessed. It might be easier to identify them if, in passing sentence, the criminal justice system could consider additional factors, e.g., evidence regarding a dealer's position in the distribution hierarchy. Such factors, ignored by mandatory minimums, can be taken into account by judges working under discretionary sentencing.

LEARNING FROM PAST MISTAKES: SIX CAVEATS

This nation's drug laws and policies have not been working well; on that simple statement almost all Americans seem agreed. During the fifty seven years since passage of the Harrison Narcotic Act, heroin has become a national menace; its- use has even spread to the middle class and the suburbs. After a third of a century of escalating penalties against marijuana and of anti-marijuana propaganda, marijuana has reached an unprecedented peak of popularity. After a decade of agitation and legislation, LSD-a drug few people had even heard of before 1962-is now known universally and used by hundreds of thousands, even high-school students. The barbiturates, which a generation ago were thought of as sedatives, useful for calming and for sleep, have become "thrill drugs." So have the amphetamines, once used mainly to enable people to work longer hours at hard jobs.

These changes, clearly, are not the result of changes in the chemical composition of the drugs. They are the result of mistaken laws and policies, of mistaken attitudes toward drugs, and of futile, however well intentioned, efforts to , stamp out the drug menace." This Consumers Union Report, accordingly, has been only partly concerned with the "drug problem." Large portions of our work have focused instead on what Dr. Helen Nowlis has aptly called "the drug problem" -the damage that results from the ways in which society has approached the drug problem.

To summarize here the entire contents of this Report would be an impossible undertaking. We therefore present instead a series of brief reminders of some of the central themes developed earlier, plus drug-by-drug recommendations growing out of those themes.

Our recommendations are not intended as a blueprint for solving overnight either "the drug problem" or "the drug problem." Rather, each proposal is put forward as an approach worthy of consideration and trial. As the drug scene changes, new recommendations will no doubt be called for.

Mistakes in drug laws, policies, and attitudes are discussed and documented throughout this Report. Among the steps which might correct them, we suggest the following:

(1) Stop emphasizing measures designed to keep drugs away from people.

Prohibition-trying to keep drugs away from people-began with the enforcement of the 1914 Harrison Narcotic Act, and it has remained the dominant theme of both anti drug legislation and anti drug propaganda ever since. Prohibition does not work.

As the United States learned from 1920 to 1933, it didn't work with alcohol. As the country has been learning since

1914, it doesn't work with heroin. It isn't working today with marijuana, LSD, or any of the other illicit drugs. Nor is prohibition likely to prove more effective in the future.

What prohibition does accomplish is to raise prices and thus to attract more entrepreneurs to the black market. If the drug is addicting and the price escalation is carried to outrageous extremes (as in the case of heroin), addicts resort to crime to finance their purchases-at a tragic cost, not only in dollars but in community disruption.

What prohibition also achieves is to convert the market from relatively bland, bulky substances to more hazardous concentrates which are more readily smugglable and marketable-from opium smoking to heroin mainlining, from coca leaves to cocaine, from marijuana to hashish.

Again, prohibition opens the door to adulterated and contaminated drugs-methyl alcohol, "ginger jake," pseudo-LSD, adulterated heroin. Worst of all, excessive reliance on prohibition, on laws and law enforcement, lulls the country decade after decade into a false confidence that nothing more need be done-except to pass yet another law, or to hire a few hundred more narcotics agents, or to license the agents to break down doors without knocking first, and so on.

This is not, obviously, a justification for repealing all drug laws tomorrow. A nation that has not learned to keep away from some drugs and to use others wisely cannot be taught those essential lessons merely by repealing drug laws. What is needed in the legal arena are two fresh insights:

Physicians have a maxim:

It means that a physician must guard against doing more harm than good. A nihil nocere guideline is needed for drug laws and law enforcement. A law-enforcement policy that converts marijuana smokers into LSD or heroin users (see chart on Page 442), to cite an obvious example, should be abandoned. The same is true of a law that turns marijuana smokers into convicts and ex-convicts, with all that the prison experience and the prison record implies. Nor can much be

said in favor of a law-enforcement policy that results in raising the price of a nickel's worth of heroin to five dollars- with the further result that addicts must steal vast amounts in order to buy their heroin.

A complete revision of laws and enforcement policies in the spirit of the nihil nocere principle is called for. Laws and law enforcement cannot solve the drug problem- they should not be allowed to exacerbate it. A realistic understanding of what laws can and cannot do is needed. Laws cannot work miracles. They cannot, for example, keep heroin away from heroin addicts, nor marijuana away from marijuana smokers. The most laws can do in these cases is to punish and to alienate. Accordingly, laws and enforcement policies should be revised to concentrate on achievable goals. For example, in countries where heroin addicts do not have to patronize and support a black market, law-enforcement efforts can be directed solely toward curbing the flow of heroin to non addicts. Surely this is the essential goal.

In sum, valuable resources and energies should no longer be wasted chasing prohibition will-o'-the-wisps, Those goals that cannot be achieved by law enforcement should be assigned to other instrumentality's such as education and social reform.

Stop publicizing the horrors of the "drug menace." Scare publicity has been the second cornerstone of national policy, along with law enforcement, since 1914. The effort to frighten people away from illicit drugs has publicized and thus popularized the drugs attacked. The impact on young eyes and ears of the constant drumming of drug news stories and anti drug messages is clearly discernible-just look around.*

Ken Sobol wrote in the New York Village Voice, October 21, 1971: "in the past week we were entertained [on television] by seven dope discussion/documentaries, a dope agony ballet, two dope poetry readings, innumerable anti-dope commercials, and three dramatic series shows centering around junkies.

Not to mention Rona Barrett revealing Hollywood's latest hothead horror, a variety show host wittily confusing grass and grass, Jim Jensen crackling gravely as he narrated the [New York Police Department's] 'biggest raid of the week' bit, LeRoi Jones accusing the Pope of dealing, and countless other pieces of programs. Reds, greens, tips, downs, agony, ecstasy, sniff, smoke, mainline, degradation, or rehabilitation-you name it, we had it, as usual. "All of these items began with the assumption that since dope is an evil, its horrors must be portrayed as graphically as possible in order to educate the viewer. But the question which nobody seems to ask is just what is being taught by all this electronic moralizing-that drugs are bad, or that Dope Is Exciting! Like 'everything else on TV, dope 'education' is show biz. And like all show biz, it is glamorous form first, content second. One National Football League anti-drug spot begins with exciting field action, while up tempo, big band jazz blares over. Then, as the music recedes, the camera picks out one player smashing an opposing ballcarrier and we hear his voice over: 'This is Mike Reid That's the way I like to crack down. I'd like to rack up the drug traffic, too.' Up jazz , building to crash climax. it's all groovy sounds and fast action, only slightly interrupted by some rich jock's [anti-drug comments]. Wham, bam, dope, man! Dope is so exciting that even the anti-dope swings. "That impression is enhanced by the fact that only beautiful, vibrant people turn to drugs on entertainment TV. Last Friday, for one example, among many, the 'DA,' a new NBC law and order hour, had a show about a junkie witness. She was, of course, young, beautiful, intelligent, and paying for her mistakes. Decadence sells better than ever these days. It makes people romantically exciting, cool, tragic and plugged in-beautiful people, that is. "Even documentary dope can be a gas.

In Frederick Wiseman's 'Hospital,' shown last week on NET, a long sequence (which I am pulling out of context) shows a bad tripping teenaged boy in the emergency room.

He screams, moans, shakes, crawls in his own puke, begs the doctors not to let him die. All genuine, all riveting. Yet at the same time completely unreal, because the TV screen automatically distances us and makes it a performance-a show about a-kid connecting with life in the rawest, most primal way. And again, I think that what may remain in the mind from it is the Generalized excitement of that elemental connection, rather than its individual real-life horror. Because TV is not real life, and while it is surprisingly easy to ignore some one else's horror on film, it is no trick at all to get excited by it. "So there you are. A small piece of last week's junk action . Next week there will be more of the same, and more the week after, and so on, until we have theoretically been 'educated' or frightened off dope-or on to it. Because if McLuban is at all right, then some people are going about this all wrong. Maybe there is no right way to treat dope on television as it is presently constituted, but I wish to hell someone in a foundation or school somewhere would at least sit down and worry about it."

As shown throughout this Report, sensationalist publicity is not only ineffective but counterproductive. Both the peril and the warning function as lures. At the same time, the anti drug campaigns have inflamed the hostile emotions of many non-drug users, making it harder to win support for calm, rational, non punitive, effective drug policies.

(3) Stop increasing the damage done by drugs. Current drug laws and policies make drugs more rather than less damaging in many ways. The alleged justification for this is, of course, to deter people from using drugs. Thus, the sale or possession of hypodermic needles without prescription is a criminal offense-a policy which leads to the use of non sterile needles, to the sharing of needles, and to epidemics of hepatitis and other crippling, sometimes fatal, needle-borne diseases. Contaminated and adulterated illicit drugs circulate as freely as pure illicit drugs, with no greater penalty for selling them and no effective system for warning users against them. Only trifling efforts are made to find and eliminate the cause of the hundreds of deaths each year among heroin mainliners—deaths falsely attributed to "overdose." The establishment of methadone maintenance programs for heroin addicts is resisted and delayed in part because some people want heroin addiction to lead to disaster-as a deterrent to others. Loss of employment, expulsion from school, and exclusion from respectable society

similarly serve to increase the damage done by drugs-and over all of the other penalties hovers society's ultimate sanction, imprisonment, the most damaging of all consequences of illicit drug use.

(4) These and other drug laws and policies have succeeded in making drug use more damaging in the United States than in other countries, and vastly more damaging today than in the United States of a century ago. But as deterrents against drug use, these policies clearly have failed. Accordingly, future efforts should be directed toward minimizing the damage done by drugs.

A substantial part of that damage stems not from the chemistry of the drugs but from the ignorant and imprudent ways in which they are used, the settings in which they are used, the laws punishing their use, society's attitudes toward users, and so on. Once a policy of minimizing damage is adopted and conscientiously pursued, a substantial part of the "drug menace" will be eliminated-even though many people may continue to use drugs.

The choice is clear: to continue trying, ineffectively, to stamp out illicit drug use by making-it as damaging as possible, or to seek to minimize the damage done by drugs, licit and illicit alike.*

The first faint harbingers of a trend toward lessening drug damage are beginning to appear. Some people who thought a few years ago that imprisonment or death was good enough for "drug fiends" whose skin color was different or who lived in another part of town have begun to change their minds as they realize that the users of illicit drugs include their own children. Actions by both Congress and a number of state legislatures to reduce marijuana possession penalties in 1970 and 1971 were straws in this breeze of change. The concern expressed in 1971 for veterans returning from Vietnam addicted to heroin was another straw. The problem of minimizing the damage done by licit drugs, such as nicotine and alcohol, also attracted Congressional attention in 1970 and 1971; cigarette advertising was banned from television and new alcoholism treatment and research programs were authorized. Several states repealed their laws making public drunkenness a crime punishable by imprisonment.

(4) Stop mis-classifying drugs. Misclassification lies close to the heart of the drug problem, for what teachers tell students about a drug, and how judges sentence drug-law violators, both depend on how the drug is classified. Most official and unofficial classifications of drugs are illogical and capricious; they therefore make a mockery of drug-law enforcement and bring drug education into disrepute.

A major error of the current drug classification system is that it treats alcohol and nicotine-two of the most harmful drugs-essentially as non drugs.* Equating marijuana with heroin is a second shocking example for it helps to encourage the switch from marijuana to heroin.

Some young people, baffled by the illogic, have concluded that corrupt legislators must have adopted the classifications to protect the tobacco and alcohol industries. Such distrust is perhaps understandable, though ignorance rather than venality seems the more likely explanation. The fact remains, however, that a significant part of American agriculture and industry is engaged, with government support, in the production and marketing of nicotine and alcohol products.

The entire jarred-built structure of official drug classification rests on a series of Congressional enactment's beginning in 1914 and reaching a climax in the Comprehensive Drug Abuse Prevention and Control Act of 1970. The misclassifications built into this Act were not the results of scientific study but represented compromises between Senate and House committees, between Republican and Democratic legislators, between Congress and the Nixon administration. Worse yet, the Act authorizes the Attorney General of the United States to alter the classifications from time to time. Yet judges are bound by this political rather than scientific system of classification in assessing penalties; and educational programs generally take their cue from the official classification.

Propaganda programs contribute to the classification chaos in another way; they accent the distinction between licit and illicit drugs, while failing to draw distinctions between more hazardous and less hazardous illicit drugs. The result is to facilitate the use of the more hazardous illicit drugs. A sound classification program should concern itself with modes of drug use as well as drugs themselves; it should recognize, for example, the vast difference between sniffing, smoking, or swallowing a drug and mainlining it.

Society, laws, and law-enforcement policies already differentiate the occasional drinker of a glass of wine or beer, the social drinker, the problem drinker, the spree drinker, the chronic drunk, and the alcoholic. Similar distinctions should be made with respect to various modes of use of marijuana, LSD, the barbiturates, and the amphetamines. It is one thing to get stoned on marijuana on Saturday night; it is quite another to stay stoned all day every day. A sensible drug classification program would not only recognize but stress the difference. Once a reasonable approach is adopted to the

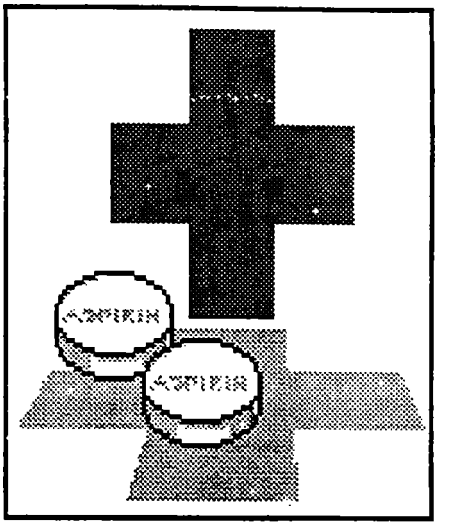
classification of drugs and modes of drug use, educators can begin to plan a believable program of drug education, based on truth-on what is known and not known. Such a program will be confirmed by what young people see around them, and by what they experience if and when they try drugs themselves. It will therefore no longer bring down ridicule and disrepute upon the whole concept of drug education. Until drugs are sensibly reclassified, no amount of public-relations expertise will restore credibility to governmental, medical, and educational drug pronouncements.

(5) Stop viewing the drug problem as primarily a national problem, to be solved on a national scale. In fact, as workers in the drug scene confirm, the "drug problem" is a collection of local problems. The predominant drugs differ from place to place and from time to time. Effective solutions to problems also vary; a plan that works now for New York City may not be applicable to upstate New York and vice versa. With respect to education and propaganda, the need for local wisdom and local control is particularly pressing. Warning children against drugs readily available to them is a risky business at best, requiring careful, truthful, non sensational approaches. Warning children against drugs used elsewhere, of which they may never have heard, can be like warning them against putting beans in their ears. The role of anti-glue-sniffing warnings in popularizing glue sniffing is the most striking of many examples.

The errors in drug policy under review here are also generalizations that may or may not be relevant in a particular community. An essential preliminary step in any local drug education program should be to identify the errors in policy currently being committed locally-and, if possible, to correct them locally.

(6) Stop pursuing the goal of stamping out illicit drug use. If, in 1937, efforts had been undertaken to reduce marijuana smoking over a period of years rather than to try to eradicate it immediately, such a program might well have succeeded. Instead, one of the greatest drug explosions in history-the marijuana eruption of the 1960s-was triggered. Attempts to stamp out illicit drug use tend to increase both drug use and drug damage. Here LSD is the prime example. Finally, as we have shown, efforts to stamp out one drug shift users to another-from marijuana to LSD and heroin, from heroin to alcohol. These, then, are the major mistakes in drug policy as we see them.

Ibogaine



On August 25, 1993, the Drug Abuse Advisory Committee of the U.S. Food and Drug Administration (FDA) voted to permit an individual academic investigator to conduct a limited human investigation of ibogaine. Ibogaine is believed by some to interrupt the addiction of some heroin- and cocaine-dependent persons. Ibogaine comes from the root of the iboga plant found primarily in certain West African nations and is used in certain African rituals. Ibogaine also is reported to be a hallucinogenic drug.

As part of its Medications Development Program, the National Institute on Drug Abuse sponsored much of the pre-clinical scientific research on ibogaine that has assisted the FDA and its Drug Abuse Advisory Committee in the review of the compound for clinical safety trials.

NIDA decided to evaluate ibogaine as a potential treatment medication in April 1991, after NDA International, Inc., met with NIDA with compelling anecdotes from about 25 heroin addicts who reported losing their craving for heroin after taking ibogaine. In May 1991, NIDA formed a project team to evaluate ibogaine in the same manner as it would any other potential medication: by following the medication development process of studies involving chemistry, dosage form development, pharmacokinetics, pharmacology, animal safety, and human clinical trials, if warranted. The pre-clinical portion of the project is currently proceeding and is focused on three major issues: the toxicology of ibogaine, the development of an assay for ibogaine and its metabolites in biological fluids, and the development of a suitable dosage form of ibogaine.

Prior to conducting any studies on ibogaine, it was necessary for NIDA to take several actions. First, NIDA had to arrange to acquire ibogaine, controlled under the Controlled Substances Act as a Schedule I drug, the most restricted classification, as having no medical utility. NIDA awarded contracts and worked with the U.S. Drug Enforcement Administration (DEA) to secure registration for its grantees and contractors to legally acquire and study this Schedule I compound. These steps were accomplished in about 16 months. Next, NIDA prepared to analyze ibogaine by conducting chemistry, pharmacokinetics, and pharmacology and toxicology studies, because there were few pre-clinical or clinical data that would meet FDA Good Laboratory Practices and Good Clinical Practices guidelines.

Shortly after obtaining ibogaine in August 1992, NIDA began its first study with it. Since then, NIDA has sponsored 18 animal studies to evaluate the pharmacology and toxicology of ibogaine. NIDA is continuing to work toward developing the necessary pre-clinical safety data to assess the possibility of additional clinical trials (human testing), if warranted.

During this testing, a NIDA contractor discovered a specific dose-related neurotoxicity in rats. This finding does not preclude evaluation of ibogaine at this point because there may be species differences and an effective dose at which this neurotoxicity does not occur. NIDA will, however, be conducting more studies on other species to further evaluate and define ibogaine's toxicological profile.

NIDA also will be following and evaluating the results of any other testing performed by sources receiving outside funding, as they become available.

Part of the NIDA Capsule Series - (C-93-04)

The Consumers Union Report on Licit and Illicit Drugs

by Edward M. Brecher and the Editors of Consumer Reports Magazine, 1972

1. Nineteenth-century America - a "dope fiend's paradise"

The United States of America during the nineteenth century could quite properly be described as a "dope fiend's paradise." Opium was on legal sale conveniently and at low prices throughout the century; morphine came into common use during and after the Civil War; and heroin was marketed toward the end of the century. These opiates and countless pharmaceutical preparations containing them "were as freely accessible as aspirin is today."1 They flowed mostly through five broad channels of distribution, all of them quite legal:

1) Physicians dispensed opiates directly to patients, or wrote prescriptions for them.

(2) Drugstores sold opiates over the counter to customers without a prescription.

(3) Grocery and general stores as well as pharmacies stocked and sold opiates. An 1883--1885 survey of the state of Iowa, which then had a population of less than 2,000,000, found 3,000 stores in the state where opiates were on sale-and this did not include the physicians who dispensed opiates directly.2

(4) For users unable or unwilling to patronize a nearby store, opiates could be ordered by mail.

(5) Finally, there were countless patent medicines on the market containing opium or morphine. They were sold under such names as Ayer's Cherry Pectoral, Mrs. Winslow's Soothing Syrup, Darby's Carminative, Godfrey's Cordial, McMunn's Elixir of Opium, Dover's Powder,3 and so on. Some were teething syrups for young children, some were "soothing syrups," some were recommended for diarrhea and dysentery or for "women's trouble." They were widely advertised in newspapers and magazines and on billboards as "pain-killers," "cough mixtures," "women's friends, "consumption cures," and so on.4 One wholesale drug house, it is said, distributed more than 600 proprietary medicines and other products containing opiates.5

Most of the opium consumed in the United States during the nineteenth century was legally imported. Morphine was legally manufactured here from the imported opium.6 But opium poppies were also legally grown within the United States. One early reference-perhaps the earliest -was in a letter from a Philadelphia physician, Dr. Thomas Bond, who wrote to a Pennsylvania farmer on August 24, 1781: "The opium you sent is pure and of good quality. I hope you will take care of the seed."7 During the War of 1812, opium was scarce, but "some parties produced it in New Hampshire and sold the product at from $10 to $12 per pound." 8

In 1871 a Massachusetts official reported:

> There are so many channels through which the drug may be brought into the State, that I suppose it would be almost impossible to determine how much foreign opium is used here; but it may easily be shown that the home production increases every year. Opium has been recently made from white poppies, cultivated for the purpose, in Vermont, New Hampshire, and Connecticut, the annual production being estimated by hundreds of pounds, and this has generally been absorbed in the communities where it is made. It has also been brought here from Florida and Louisiana, while comparatively large quantities are regularly sent east from California and Arizona, where its cultivation is becoming an important branch of industry, ten acres of poppies being said to yield, in Arizona, twelve hundred pounds of opium.9

Opium was also produced in the Confederate states (Virginia, Tennessee, South Carolina, Georgia) 10 during the Civil War-and perhaps thereafter. Though some states outlawed it earlier, Congress did not ban the cultivation of opium poppies nationally until 1942.11

The nineteenth-century distribution system reached into towns, villages, and hamlets as well as the large cities. A New England physician-druggist wrote about 1870:

> In this town I began business twenty years since. The population then at 10,000 has increased only inconsiderably, but my sales have advanced from 50 pounds of opium the first year to 300 pounds now; and of laudanum [opium in alcohol] four times upon what was formerly required. About 50 regular purchasers come to my shop, and as many more, perhaps, are divided among the other three apothecaries in the place. Some country dealers also have their quota of dependents.12

A correspondent for the Portland (Maine) Press had this to say about opium users in 1868: "In the little village of Auburn ... at least fifty such (as counted up by a resident apothecary) regularly purchase their supplies hereabouts; and the country grocers too, not a few of them, find occasion for keeping themselves supplied with a stock." 13
A survey of 10,000 prescriptions filled by thirty-five Boston drugstores in 1888 revealed that 1,481 of them contained opiates. Among prescriptions refilled three or more times, 78 percent contained opiates .14

One Massachusetts druggist, asked to review his opiate sales, added a picturesque detail. He bad only one steady customer, be reported - and that a noted temperance lecturer." 15
Nor was the Middle West different from New England. The Annual Report of the Michigan State Board of Health for 1878 reported three opium eaters in the village of Huron (population 437), four opium eaters and one morphine cater in the village of Otisville (population 1,365), 18 opium eaters and 20 morphine eaters in the town of Hillsdale (population 4,189), and so on around the state.16 Some children were included in the statistics.

Though called "opium eaters" in the medical literature, most nineteenth century opium users (including Thomas De Quincey, author of Confessions of an English Opium-Eater) were in fact opium drinkers; they drank laudanum or other opiate liquids. Similarly "morphine eaters" included many who took morphine by injection or in other ways. In a number of the quotations which follow, "opium eaters" refers generally to morphine as well as opium users. Opium smokers, however, were considered to be in a separate category (see Chapter 6).

The nineteenth-century use of opiates was more or less the same in Britain. A classic report on the English industrial system, The Factory System Illustrated (1842), by W. Dodd, noted that factory workers of the time used opiates-notably laudanum-to quiet crying babies.17

In the official Report of the Medical Officer of the Privy Council for 1864 it was observed: "To push the sale of opiate ... is the great aim of some enterprising wholesale merchants. By druggists it is considered the leading article."18 The report also noted the giving of opiates to infants; 19 Karl Marx, citing this report in Capital (1867), spoke of the English working-class

custom of "dosing children with opiates ." 20 In 1873 an English physician reported:

> ... Amongst the three millions and three-quarters [people in London] there are to be found some persons here and there who take [opium] as a luxury, though by far the greater number of those who take it in anything like quantity do so for some old neuralgia or rheumatic malady, and began under medical advice. Neither is it to be found over the agricultural or manufacturing districts, save in the most scattered and casual way. The genuine opium-eating districts are the ague and fen districts of Norfolk and Lincolnshire. There it is not casual, accidental, or rare, but popular, habitual, and common.
>
> Anyone who visits such a town as Louth or Wisbeach, and strolls about the streets on a Saturday evening, watching the country people as they do their marketing, may soon satisfy himself that the crowds in the chemists' shops come for opium; and they have a peculiar way of getting it. They go in, lay down their money, and receive the opium pills in exchange without saving a word
>
> . For instance, I was at Wisbeach one evening in August 1871; went into a chemist's shop; laid a penny on the counter. The chemist said - "The best?" I nodded. He gave me a pill box and took up the penny; and so the purchase was completed without my having uttered a syllable. You offer money, and get opium as a matter of course. This may show how familiar the custom is....
>
> In these districts it is taken by people of all classes, but especially by the poor and miserable, and by those who in other districts would seek comfort from gin or beer.21

Godfrey's Cordial-a mixture of opium, molasses for sweetening, and sassafras for flavoring-was especially popular in England. Dr. C. Fraser Brockington reports that in mid-nineteenth-century Coventry, ten gallons of Godfrey's Cordial enough for 12,000 doses-was sold weekly, and was administered to 3,000 infants under two years of age.

> Even greater quantities of opium mixtures were said to be sold in Nottingham.... Every surgeon in Marshland testified to the fact that "there was not a labourer's house in which the bottle of opium was not to be seen, and not a child, but who got it in some form." . . . Wholesale druggists reported the sale of immense quantities of opium; a retail druggist dispensed up to 200 pounds a year-in pills and penny sticks or as Godfrey's Cordial.... To some extent this was a

> practice which had been taken on during the years when malaria was indigenous in the Fens and when, a century before, the poppy had been cultivated for the London market. 22

The nonmedicinal use of opiates, while legal in both the United States and England, was not considered respectable. Indeed, as an anonymous but perceptive and well-informed American writer noted in the Catholic World for September 1881, it was as disreputable as drinking alcoholic beverages-and much harder to detect:

> The gentleman who would not be seen in a bar-room, however respectable, or who would not purchase liquor and use it at home, lest the odor might be detected upon his person, procures his supply of morphine and has it in his pocket ready for instantaneous use. It is odorless and occupies but little space. . . . He zealously guards his secret from his nearest friend-for popular wisdom has branded as a disgrace that which he regards as a misfortune. . .23

Opiate use was also frowned upon in some circles as immoral-a vice akin to dancing, smoking, theater-going, gambling, or sexual promiscuity. But while deemed immoral, it is important to note that opiate use in the nineteenth century was not subject to the moral sanctions current today. Employees were not fired for addiction. Wives did not divorce their addicted husbands, or husbands their addicted wives. Children were not taken from their homes and lodged in foster homes or institutions because one or both parents were addicted. Addicts continued to participate fully in the life of the community. Addicted children and young people continued to go to school, Sunday School, and college. Thus, the nineteenth century avoided one of the most disastrous effects of current narcotics laws and attitudes-the rise of a deviant addict subculture, cut off from respectable society and without a "road back" to respectability.

Our nineteenth-century forbears correctly perceived the major objection to the opiates. They are addicting. Though the word "addiction" was seldom used during the nineteenth century, the phenomenon was well understood. The true nature of the narcotic evil becomes visible, the Catholic World article pointed out, when someone who has been using an opiate for some time attempts to give up its use. Suddenly his eyes are opened to his folly and he realizes the startling fact that he is in the toils of a serpent as merciless as the boa-constrictor and as relentless as fate. With a firm determination to free himself he discontinues its use. Now his sufferings begin and steadily increase until they become unbearable. The tortures of Dives are his; but unlike that miser, he has only to stretch forth his hand

to find oceans with which to satisfy his thirst. That human nature is not often equal to so extraordinary a self-denial affords little cause for astonishment. . . . Again and again he essays release from a bondage so humiliating, but meets with failure only, and at last submits to his fate a confirmed opium-eater.24

Our nineteenth-century forbears also perceived opiate use as a "will-weakening" vice-for surely, they insisted, a man or woman of strong will could stop if he tried hard enough. The fact was generally known that addicts deprived of their opiates (when hospitalized for some illness unrelated to their addiction, for example) would lie or even steal to get their drug, and addicts "cured" of their addiction repeatedly relapsed. Hence there was much talk of the moral degeneration caused by the opiates. Nevertheless, there was very little popular support for a law banning these substances. "Powerful organizations for the suppression ... of alcoholic stimulants exist throughout the land,"25 the 1881 article in the Catholic World noted, but there were no similar anti-opiate organizations.

The reason for this lack of demand for opiate prohibition was quite simple: the drugs were not viewed as a menace to society

The Consumers Union Report on Licit and Illicit Drugs

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OPIUM SMOKING IS OUTLAWED:

To summarize the data reviewed so far, opiates taken daily in large doses by addicts were not a social menace under nineteenth-century conditions, and were not perceived as a menace. Opium, morphine, and heroin could be legally purchased without a prescription, and there was little demand for opiate prohibition. But there was one exception to this general tolerance of the opiates. In 1875, the City of San Francisco adopted an ordinance prohibiting the smoking of opium in smoking-houses or "dens." 1

The roots of this ordinance were racist rather than health-oriented, and were concerned with what today is known as 'life-style." Opium smoking was introduced into the United States by tens of thousands of Chinese men and boys imported during the 1850s and 1880s to build the great Western railroads.* The Chinese laborers then drifted into San Francisco and other cities, and accepted employment of various kinds at low wages -giving rise to waves of anti-Chinese hostility. Soon white men and even women were smoking opium side by side with the Chinese, a life-style which was widely disapproved. The San Francisco authorities, we are told learned upon investigation that "many women and young girls, as well as young men of respectable family, were being induced to visit the [Chinese] opium-smoking dens, where they were ruined morally and otherwise * The 1875 ordinance followed, "forbidding the practice under penalty of a heavy fine or imprisonment or both. Many arrests were made, and the punishment was prompt and thorough.- 6

*** Professor Jonathan Spence of the Department of History, Yale University, presented a fascinating account of opium smoking in nineteenth-century China at the Conference on Local Control and Social Protest during the Ch'ing Period, hold at Honolulu, Hawaii, from June 27 to July a, 1971. He reported, for example, that "opium was highly regarded in China, both as a medicinal drug (that checked diarrhea and served as a febrifuge), and as an aphrodisiac. Therefore people might become addicted either became they took opium intensively during an illness hr instance in the great cholera epidemic of 1821-or because they had vigor, leisure and money and wanted to make the best of it. 'Those who ate regularly and well did not suffer physiologically from their addiction, but for the poor, addiction was a serious health hazard (even though, ironically, it was often first taken for health reasons), since scarce cash resources were put to opium rather than food purchases. The rewards for the poor were a blurring of the pains of prolonged labor, and an increase in work capacity over short periods of time. Then there was heavy addiction among coolies and chair-bearers, and among such groups as boatmen who had to work their boats upstream, and stone-cutters working out-of-doors in cold weather.**

The last Chinese to become addicted seem to have been the peasants, though as they grew more opium crops the incidence heavy opium smoking rose, and by 1902 one could find entire rural communities that were in desperate straits because addiction had become almost total. By the late Ch'ing, it scans that no major occupational group was without its addicts.

~* One white girl of good family and education began opium smoking at sixteen in San Francisco in 1880, later became a prostitute, moved to Victoria, British Columbia, and was found in an opium den in 1884 by a Royal Commission. The transcript of her answers to questions reads, in part:

Q. Why did you commence to smoke opium?
A. Why do people commence to drink? Trouble, I suppose led me to smoke. I think it is better than drink. People who smoke opium do not kick up rows; they injure no one but themselves, and I do not think they injure themselves very much.
Q.... Why do you smoke now?
A. Because I must; I could not live without it. I smoke partly because of the quiet enjoyment it gives, but mainly to escape from the horrors which would ensue if I not smoke. To be twenty-four hours without smoking is to suffer worse tortures than the lost.
Q. But does not the smoking make you wretched, past as drinking would?
A. No; I require about twelve pipes, then I fall into a state of somnolence and complete rest. When I awake I feel all right, and can attend to fixing-up the house. I am brisk, and can work as well as anybody else. I do not feel sick or nervous, neither have I the inclination to smoke more opium.
O. Then why do you return to the use of the drug?
A. Ah! that's it; there is a time when my hands fail me; tears fall from my eyes, I am ready to sink; then I come here and for a few bits have a smoke which sets me right. There is too much nonsense talked about opium-smoking. Life without it would be unendurable, I am in excellent health; but, I suppose, every one has their own troubles, and I have mine.
Q. I do not want to be offensive, but are you what is called a fast woman?
A. I am. But you would be greatly mistaken if you imagined that all the women who come here to smoke are of that character. In San Francisco I have known some of the first people visit opium houses, and many respectable people do the same here.
Q. Are women of your class generally addicted to opium-smoking?
A. No; they are more addicted to drink, and drink does them far more harm. Drink excites passions, whereas this allays it; and when a fast woman drinks she goes to min pretty quick....
Q. Have you anything else to add . . . ?
A. No; I would say this, though: that if opium houses were licensed as drinking saloons are one need not have to come into such holes as this to smoke. There would be nice rooms with nice couches, and the degradation would be mitigated.

At all events I think the government that will not license an opium saloon should shut up public houses and hotels where they sell vitriol for whiskey and brandy, and where men idle themselves with a certainty and a rapidity beyond the power of opium.'

This first law, however, like so many subsequent antinarcotics laws, failed to despite the promptness and thoroughness of the punishment. When opium dens became illegal, "The vice was indulged in much less openly, but none the less extensively, for although the larger smoking-houses were closed, the small dens in Chinatown were well patronized, and the vice grew surely and steadily.". Indeed, the new law "seemed to add zest to their enjoyment." 7 A similar ordinance was passed in Virginia City, Nevada, the following year.8 This also failed to accomplish its purpose; hence the State of Nevada passed a more stringent act a year or two later.6 Other states and cities voted similar statutes soon after.

When these laws failed as well, Congress took a hand. Before opium can be smoked, it must be specially prepared; and weak opium containing less than the usual amount of morphine is used in its preparation. In 1883, Congress raised the tariff on opium prepared for smoking from $6 to $10 a pound; '° and in 1887 it prohibited altogether the importation of the kind of weak opium-that containing less than 9 percent morphine- used for preparing smoking opium. The 1887 law also prohibited the importation of opium by Chinese, and a law three years later limited the manufacture of smoking opium to American citizens.11 The results of these steps were set forth in a letter dated January 12, 1888, from the Secretary of the Treasury of the United States to the Speaker of the House of Representatives. The effect, he wrote, had been "to stimulate smuggling, extensively practiced by systematic organizations [presumably the Chinese "tongs" or mutual benefit societies on the Pacific coast. Recently completed facilities for transcontinental transportation have enabled the opium smugglers to extend their illicit traffic to our Northern border. Although all possible efforts have been made by this Department to suppress the traffic, it is found practically impossible to do so." 12

The law was not changed, however; indeed, the tariff on smoking opium was further increased, from $10 to $12 per pound in 1890. Then, in 1897, it was reduced to $6 a pound "experience having at last taught that it could not bear a higher rate without begetting an extensive surreptitious manufacture or serious smuggling operations." Following the reduction in the tariff, "the amount that passed through the customs houses . . . progressively increased." 13

Throughout this period, states and cities continued to pass laws against opium smoking;* by 1914 there were twenty-seven such laws in effect.. Yet the amount of smoking opium legally imported continued to rise steadily, as shown in Table 2. 14

During more than thirty years of city, state, and federal efforts to suppress opium smoking, the amount smoked per year increased sevenfold-without taking account of smuggled supplies.

In 1909, the importation of smoking opium was prohibited altogether.15 This law was successful in the sense that smoking opium imported through the customhouses fell to zero, but it did not solve the opium-smoking problem. Congress in January 1914 found it necessary to amend the 1909 law 16 and to pass an additional statute imposing a prohibitive tax ($300 per pound) on opium prepared for smoking within the United States.7 In December 1914 Congress passed the Harrison Narcotic Act, with far broader provisional.

Yet as late as 1930, according to Federal Narcotics Commissioner Harry J. Anslinger and United States Attorney William F. Tompkins, "opium dens could be found in almost any American city." 19

Decade	Pounds of Smoking Opium Imported	Number of Smokers Who Could Be Supplied a
1860-69	21,176	8,470
1870~79	48,049	19,219
1880~89	85,988	34.395
1890~99	92,462	36,985
1900~09	148,168	59,287

At 21/2 pounds per year.

Table 2. Rise in Legal importation of Opium, 1860- 1909.

One reason for the failure of these anti-opium-smoking laws, and of subsequent anti narcotics laws, appears obvious. They were aimed at private transactions between willing sellers and willing, usually eager, buyers Thus there were no complainants. Other such laws include the Volstead Act, since repealed, which prohibited the sale of alcoholic beverages; the laws against fornication, homosexual acts, and other sexual acts between consenting individuals in private; the laws against gambling; and the drug laws generally. The phrase "crimes without victims" has been applied to such acts; they can more accurately be called "crimes without complainants."

It is hard to cite a law aimed at crimes of this class which has had much effect in curbing the behavior aimed at..*

* -all laws which can be violated without doing any one an injury are laughed at. Nay, so far are they from doing anything to control the desires and passions of men that, on the contrary, they direct and incite men's thoughts the more toward those wry objects; for we always strive toward what is forbidden and desire the things we are not allowed to have. And men of leisure are never deficient in the ingenuity needed to enable them to outwit laws framed to regulate things which cannot be entirely forbidden.... He who tries to determine everything by law will foment clime rather than lessen it."-Baruch Spinoza (1632-1677).20

The mere fact that a law fails to achieve its goal fully is of course not a sufficient reason for repealing it; witness the laws against murder. The basic argument against laws creating crimes without complainants must rest on evidence that they not only fail but also, in the process of failing, do more harm than good. Such evidence exists with respect to the laws against opium smoking. For one effect of these laws was to convert opium smokers to more hazardous forms of opiate use.

"Opium smoking is vastly less vicious than morphine-taking," wrote an American authority on opiates, Dr. Charles B. Towns, in 1912.21
Dr. Marie Nyswander also commented on opium smoking, in 1956:
There is a pattern of self-limitation or restraint in opium smoking as practiced in countries where it is socially acceptable. It is common for natives of these countries to indulge in opium smoking one night a week, much as Americans may indulge in alcoholic beverages at a Saturday night party.... families who accept opium smoking as part of their culture are mindful of its dangers much as we are mindful of the dangers of overindulgence in alcohol.22

The reasons for the lesser harmfulness of opium smoking in moderation are not hard to find. The opium used, as noted above, is of a specially weak type containing less than 9 percent morphine. Only about 10 percent of the morphine in this weak opium enters the vapor, and only a portion of the morphine in the vapor enters the human bloodstream when inhaled. Since the opium is heated rather than burned, only smoke-free vapor is inhaled; there are no "tars" or other carcinogens to cause cancer. The so-called "opium smoker" is actually a vapor inhaler. At a very rough estimate, a smoker would have to smoke 300 or 400 grains of opium to get a dose equivalent to the intravenous injection ("mainlining-) of one grain of heroin. Even heavy opium smokers actually smoke less than this daily.. And the opium-smoking dose is necessarily spread over a considerable span of time rather than being absorbed into the bloodstream almost instantaneously, as in mainlining.

Surely the nineteenth-century enemies of opium smoking did not and could not foresee that the new laws were starting this country down the dismal road from that relatively innocent "vice" to the intravenous injection of heroin-the dominant form of illegal opiate use today; yet that was in fact the sequel.

~ Dr. Charles B. Towns wrote (1912) "The average opium-smoker consuming twenty-five pills a day gets only the equivalent of about a quarter grain [15 milligrams] of morphine taken hypodermically or of a half grain taken by the mouth. A beginner could not smoke a quarter of that quantity.... 22
Dr. Lawrence Kolb wrote (1925): "Case 35, now thirty-eight years of age, started smoking opium twenty years ago [in 1905]. After the importation of smoking opium was prevented by law, he used morphine, and when this could no longer be secured, he changed to heroin." This was the common pattern.

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21. Cbarles B. Tow=, "The Peril of the Drug Habit," Century Magazine, 84 (1910 583.
22. Jerome H. Jaffe, in Goodman and Gilman, 3rd ed. (1965), p. 285.
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Heroin is an addicting drug

The Consumers Union Report on Licit and Illicit Drugs

by Edward M. Brecher and the Editors of Consumer Reports Magazine, 1972

Why our narcotics laws have failed:

(1) Heroin is an addicting drug :

In 1970 a ruling of the United States Food and Drug Administration was sufficient to limit severely the use of a group of chemicals known as the cyclamates, many tons of which had been marketed annually in the country's favorite soft drinks and in many other food products. No cyclamates were smuggled into the United States following the new regulation; no black market in cyclamates was established; no midnight raids on clandestine cyclamate pushers were organized-indeed, cyclamates were curtailed without (so far as is known) a single sentence of imprisonment being invoked.

Why could not the opiates be calmly and sensibly removed from the market as effortlessly as the cyclamates were? The glib answer, of course, is that the opiates are addicting. But 'addicting" is a slippery word, often misused. Let us examine a few of its multitudinous meanings.

In Roman law, to be addicted meant to be bound over or delivered over to someone by a judicial sentence; thus a prisoner of war might be addicted to some nobleman or large landowner. In sixteenth-century England, the word had the same meaning; thus a serf might be addicted to a master. But Shakespeare and others of his era perceived the marked similarity between this legal form of addiction and a man's bondage to alcoholic beverages; they therefore spoke of being addicted to alcohol. Poets also spoke of men "addicted to vice," and of young women "addicted to virginity." Dr. Johnson wrote of "addiction to tobacco" and John Stuart Mill of "addiction to bad habits." The concepts of addiction to opium, morphine, and heroin followed quite naturally.

Following the passage of the Harrison Narcotic Act in 1914, however, the meaning of the word "addicting" underwent a subtle change. The original meaning - a drug to which one becomes enslaved-was lost sight of. Many people assumed that any addict could stop taking an addicting drug if he wanted to and if he tried hard enough. The imprisonment of addicts was based on this confusion; addicts were expected to stop taking heroin for fear of imprisonment, or of repeated re-incarceration.

Along with these popular views of addiction, various medical theories of addiction have arisen. Physicians noted centuries ago that when alcoholics were abruptly deprived of alcohol, they often developed a very serious, indeed life-threatening, condition known as delirium tremens. When opium, morphine, and heroin addicts were deprived of their drug, they similarly developed a withdrawal syndrome that could be devastating, even fatal.

Dr. Jerome H. Jaffe describes the withdrawal syndrome in Goodman and Gilman's textbook:

The character and the severity of the withdrawal symptoms ... depend upon many factors, including the particular drug, the total daily dose used, the interval between doses, the duration of use, and the health and personality of the addict.... In the case of morphine or heroin ... lacrimation [excessive tearing], rhinorrhea [running nose], yawning, and perspiration appear ... the addict may fall into a tossing, restless sleep known as the "yen," which may last several hours but from which he awakens more restless and more miserable than before . . . additional signs and symptoms appear . . . dilated pupils, anorexia [loss of appetite], gooseflesh, restlessness, irritability, and tremor . . . symptoms reach their peak at 48 to 72 hours . . . increasing irritability, insomnia, marked anorexia, violent yawning, severe sneezing, lacrimation, and coryza [cold-like nasal symptoms]. Weakness and depression . . . nausea and vomiting . . . intestinal spasm and diarrhea. Heart rate and blood pressure are elevated. Marked chilliness, alternating with flushing and excessive sweating . . . waves of gooseflesh ... the skin resembles that of a plucked turkey . . . the basis of the expression "cold turkey" to signify abrupt withdrawal without treatment. Abdominal cramps and pains in the bones and muscles of the back and extremities are also characteristic, as are the muscle spasms and kicking movements that may be the basis for the expression "kicking the habit." Other signs . . . include ejaculations in men and orgasm in women.... The failure to take foods and fluids, combined with vomiting, sweating, and diarrhea, results in marked weight loss, dehydration. . . . Occasionally there is cardiovascular collapse. At any point in the course of withdrawal, the administration of a suitable narcotic will completely and dramatically suppress the symptoms of withdrawal.1

Physicians thus concluded that drugs such as alcohol and heroin produce a phenomenon known as physical dependence. An addicting drug came to mean a drug that produces physical dependence-that is, withdrawal symptoms-when the drug is abruptly discontinued.

Drugs that produce withdrawal symptoms usually also produce, as noted earlier, a phenomenon known as tolerance. This means that if the same dose is taken day after day, the effects gradually disappear. Thus a new definition was evolved: an addicting drug is one that produces both withdrawal symptoms and tolerance.

The association of addiction with withdrawal symptoms led naturally to the earliest theory of how addiction could be cured: all that was necessary was to help an addict through his withdrawal crisis. Once withdrawn from the drug, it was widely believed, he could live happily ever after as an ex-addict. This theory goes back at least to 1856, when an American pharmacologist, Dr. George B. Wood, wrote in his Treatise on Therapeutics and Pharmacology: It is satisfactory to know that this evil habit may be corrected, without great difficulty, if the patient is in earnest; and as the disorders induced by it are mainly functional, that a good degree of health may be restored.... The proper method of correcting the evil is by gradually reducing the cause; a diminution of the dose being made every day, so small as to be quite imperceptible in its effects. Supposing, for example, that a fluid ounce of laudanum [opium in alcohol] is taken daily, the abstraction of a minim [one drop] every day would lead to a cure in somewhat more than a year; and the process might be much more rapid than this.2 .'

In practice, however, the gradual withdrawal method had difficulties. Few addicts stayed with the withdrawal to the end; for while the first portion of the dose-lowering process was quite easy, suffering eventually set in-and it was thereafter prolonged rather than eased by the inadequate daily doses. As early as 1967, accordingly, a writer in the British Medical Journal expressed a contrary view: "Absolute and immediate suspension [of all opiates] is for efficacy the far more reliable plan, being less tedious, less exhausting, less the occasion of hard sufferings." 3

The debate between these two points of view-abrupt versus gradual withdrawal-continued for decades. But both sides agreed that for either type of treatment to succeed, an addict had to be "in earnest" and strongly motivated," and to have "will power"; moral weaklings failed.

The major problem with these early "cures" was that patients-whether abruptly or gradually withdrawn from their opiate-promptly relapsed and became addicted again. Nineteenth-century physicians, however, were not discouraged by this tendency to relapse: the patients, they complained, didn't really want to give up opiates. Or alternatively, they were weaklings lacking in will power. The fault was not in the treatment but in the patient. This is still a widely held view.

The next step forward in the "cure" of drug addiction was prolonged treatment. Patients might be kept in a sanitarium for a month, or six months, or even a year. After enforced abstinence for that long a period, it was universally agreed, opiate addiction must of necessity be entirely cured. After the Harrison Narcotic Act of 1914, this theory was pushed to even further extremes. Addicts were imprisoned for two years, five years, or even longer. When they thereafter promptly returned to their drugs, the same explanations were offered-lack of a desire to give up opiates, and lack of will power.

At the turn of the century the cure of opiate addiction was attempted on a scale that dwarfs even today's efforts. In 1908, for example, Hugh C. Weir reported in Putnam's Magazine: "There are forty institutions in this country advertising a cure for the drug habit, and all of them are largely patronized. One such institution at Atlanta, Georgia, has the names of over 100,000 patients whom it has treated, and there are several others that can show 50,000." 4

There is no evidence, however, that any addicts were ever actually cured at these "sanitariums." Indeed, the enormous success of the sanitariums depended on the fact that they were "revolving-door institutions." Some addicts came back to the same sanitarium again and again; others drifted from one sanitarium to another. Cases of men and women still addicted after ten or twenty "cures" were matters of common knowledge.

With the rise of the behavioral sciences in the twentieth century especially psychology, psychiatry, and sociology-the old theories of "poor motivation" and "weak will power" to explain addiction and relapse were not abandoned but simply rephrased. The newer theories fell into three main categories.

Psychological theories. Theories in this group are in general the heirs to the old "weakness of will" approach. Some of them hold that there exists an "addictive personality." The unfortunate possessors of this personality pattern are prone to become addicted, and are also prone to become re-addicted after they have been "cured." A restructuring of the personality is therefore needed. There are many variations on this theme -including Freudian views which trace addiction-proneness to factors in early childhood, existential views which associate addiction-proneness with psychological pressures and conflicts in adult life, and so on. What the views have in common is the belief that the secret of addiction lies in the psyche of the addict.

Sociological views. These views hold in general that society creates addicts and causes ex-addicts to relapse into addiction again. The sense of hopelessness and defeat among dwellers in our city slums, the sense, among young people today, of impotence to affect change, the needs of young people to belong to a group and their consequent drift into groups of heroin users-countless sociological factors such as these are cited to explain both addiction and relapse following "cure." An addict relapses, according to some sociological theories, because he returns to the same neighborhood where he became addicted and associates with addicts once more. What these theories have in common is the belief that the secret of addiction lies in the social context.

There are also, of course, combinations of psychological and sociological theories. The best-known of these is the theory underlying Synanon, Daytop, Odyssey House, Phoenix House, and numerous other "therapeutic communities." In such communities, the addict spends months or even years in a milieu designed to restructure his psyche from immature and addiction-prone into strong, self-reliant, no longer in need of a drug "crutch." Simultaneously, the therapeutic-community milieu provides the ex-addict with a drug-free social setting in which all the social pressures are directed toward abstinence rather than relapse.

Biochemical theories. These theories are of recent origin, and are held by only a few experts. They have arisen largely as a result of disenchantment with the practical failure of the psychological and sociological theories. These theories begin with the un-challengeable fact-on which all schools of thought are agreed-that the acute withdrawal symptoms suffered after an addict is deprived of his drug are genuinely biochemical in origin. The cause of these immediate withdrawal symptoms is in the structure of the chemical molecule and its effect on cells of the nervous system. Exposed regularly to opiate molecules the human nervous system adjusts to their presence-that is, becomes dependent upon them. If they are withdrawn, the nervous system becomes very seriously disturbed. The nervous system can readjust only gradually to the absence of an opiate in the way in which it initially adjusted to the presence of the opiate.

The controversial additional point urged by proponents of the biochemical theory is their conviction that the long-term outcome of opium, morphine, or heroin addiction-the craving and the tendency of addicts to resume drug-seeking behavior and to become re-addicted months or even years after withdrawal has been successfully achieved-is also a direct effect of the opiate molecule on the nervous system.

Holders of the biochemical view are not absolutists. They concede, for example, that some people are more likely to become addicted and re-addicted than others (though they tend to explain these differences in terms of differences in the nervous system as well as childhood upbringing or current psychic stresses). They also concede that some ex-addicts can go without drugs, and that psychological and social factors can increase or decrease the likelihood (or the promptness) of relapse and re-addiction. But they focus primary attention on the drug itself, and on its effects on the cells of the nervous system. The secret of addiction, they stress, lies primarily in the chemical molecule.

The vast bulk of the evidence to date, it must be pointed out, favors the psychological and sociological theories. But this may be because the vast bulk of scientific studies throughout the past century has been devoted to a search for psychological and sociological factors. The search for biochemical factors has barely begun (see below). We are hopeful that it will prove rewarding.

Fortunately, one need not here decide among these theories. Perhaps all three are true in part-or perhaps there is a fourth explanation of addiction as yet undiscovered. What can and must be done here, however, is to consider the consequences of these theories in the real, non-theoretical world. This can be done by reviewing the success (or failure) of the various treatment programs based on each theory.

The first official United States government theory following passage of the Harrison Narcotic Act of 1914 was a compromise; addicts must be deterred from using drugs by incarceration in an institution and helped to give up drugs by receiving therapy while incarcerated. Hence as early as 1919, the Narcotics Unit of the United States Treasury urged Congress to set up a chain of federal "narcotics farms" where addicts could be incarcerated and treated for their addiction. The request was often renewed; but such institutions cost money. Until 1929, Congress preferred to pass punitive rather than therapeutic legislation. Not until 1935 did the first United States Public Health Service hospital for narcotics addicts actually open its doors, in Lexington, Kentucky. It had 1,000 beds and 500 employees. Tens of thousands of addicts have been treated there, some many times over. A second hospital, at Fort Worth, followed a few years later.

Federal Narcotics Commissioner Harry J. Anslinger and United States Attorney William F. Tompkins, in The Traffic in Narcotics (1953), reported on the success of the Lexington hospital:

The bright side ... is the Lexington story. From 1935 to 1952, 18,000 addicts were admitted for treatment. Of these 64 percent never returned for treatment, 21 percent returned a second time, 6 percent a third time, and 9 percent four or more times. These figures should give everyone confidence that the U.S. Public Health Service Hospitals can secure good results in one of medicine's most tremendously difficult tasks.5

The flaw in Commissioner Anslinger's figures, obviously, is that they refer only to patients who returned to Lexington up to 1952. Addicts released from Lexington who returned to other hospitals, or went to prisons, or who merely continued their addiction at home, or who were to return to Lexington after 1952, were included among the 64 percent who "never returned for treatment."

When we turn from official claims to actual follow-up studies, the figures are very different. One study traced 1,912 Lexington alumni for periods of from one to four and a half years. Only 6.6 percent remained abstinent throughout the follow-up period.6

A second study checked on 453 Lexington alumni six months, two years, and five years after release. Only 12 of the 453 (less than 3 percent) were abstinent on all three follow-ups. The failure rate was thus in excess of 97 percent.7

The most recent follow-up of Lexington alumni was published in 1965 by Dr. George E. Vaillant, staff psychiatrist at Lexington and later on the Harvard Medical School faculty. Dr. Vaillant reviewed the records of 100 Lexington alumni-fifty white and fifty black-who had been released from the hospital between August 1, 1952, and January 31, 1953. (The outcomes for blacks and whites did not differ significantly.) The follow-up continued for nearly twelve years, through the end of 1964. Unlike most Lexington alumni, moreover, these ex-addicts were provided with aftercare. "For several years after discharge," Dr. Vaillant explained, "virtually all the patients or their families were regularly contacted by a social agency about once every three months. . . .

In spite of these relatively favorable conditions, within two years all but ten of the 100 patients again became addicted-at least temporarily. Of the ten who did not, three died in less than four years after discharge, two turned to alcohol, three had never used narcotics more than once a day and one used drugs intermittently after discharge. In other words, virtually all patients who had been physically addicted and did not die, relapsed.8

Two of the three patients who were not addicted when they entered Lexington became addicted after discharge. "Subsequent to Lexington the 100 patients served over 350 prison terms and underwent over 200 known voluntary hospitalizations for addiction's Only 11 of the more than 200 voluntary hospitalizations were followed by apparent abstinence from narcotics for periods of one year or longer.

Despite these woeful facts, which are here quoted directly from Dr. Vaillant's own report, the Vaillant study has been cited as evidence that narcotics addiction is readily curable. This curious conclusion arose out of the fact that Dr. Vaillant also published a chart showing only 20 of his 100 addicts still addicted in 1964, twelve years after discharge from Lexington.

What happened to the other 80? Some were dead, some were now addicted to alcohol instead of heroin, some were in prisons, some were in hospitals, some had simply disappeared, and the current status of others remained in doubt.

Twenty-three were classified in the Vaillant chart as doing well in 1964-stably employed and not at the moment addicted, so far as could be determined. In this as in other studies, however, the figures at any given moment of time are misleading. For just as some of the "successes" had become re-addicted after leaving Lexington, so some could be expected to become re-addicted yet again after completion of the follow-up. The evidence for absence of addiction, moreover, depended on "statements from potentially fallible patients, relatives and parole officers," "' as Dr. Vaillant himself modestly noted; perhaps at least a few of those classified as ex-addicts were still taking heroin after all.

Citing the Vaillant report as evidence that narcotics addiction is readily curable is an example of how far some people will go to delude themselves and others. A fair summary of the findings, both positive and negative, would go something like this.

At any given time after being "cured" at Lexington, from 10 to 25 percent of graduates may appear to be abstinent, nonalcoholic, employed, and law-abiding. But only a handful at most can maintain this level of functioning throughout the ten-year period after "cure." Almost all become re-addicted and re-imprisoned early in the decade, and for most the process is repeated over and over again.

The above figures are not to the discredit of Lexington; satisfactory research of several kinds has been done there since 1935. But no cure for narcotics addiction, and no effective deterrent, was found there-or anywhere else.

The high rate of relapse even after prolonged incarceration and treatment can readilv be explained in terms of the post withdrawal syndrome -anxiety, depression, and craving-described in Chapter 2. Prolonged incarceration may postpone the drug-seeking behavior but it does not alleviate that underlying syndrome. Release from prison and from treatment may thereafter trigger an intense new wave of anxiety, depressions and craving-followed by drug-seeking behavior and relapse.

In 1961, California launched its large-scale civil commitment program for narcotics addicts. This program permits addicts to be locked tip without first being convicted of a crime. Instead of being called "prisoners" or "prison inmates," the addicts are called "residents" not of prisons but of "rehabilitation centers." Instead of being tinder the jurisdiction of prison authorities, the "residents" are held by the California Rehabilitation Center (CRC), to which they are committed for periods of up to seven years. Part of the time is spent "in residence," that is, locked up, and the rest on "outpatient status," that is, on parole. Release is supposed to follow three years of successful parole. (The constitutionality of this program of incarceration without criminal trial and conviction-and of similar New York State and federal "civil commitment" programs-has been repeatedly challenged in the courts. The challenges are from time to time successful in individual cases, but the system as a whole has to date remained impervious to constitutional attacks.)

Between September 1961 and the spring of 1968, Dr. John C. Kramer and Richard A. Bass reported in the Journal of the American Medical Association, more than 8,000 addicts or alleged addicts were Committed under the CRC program. Of these, 5,200 were still in the program in the spring of 1968. Up to that point, 3,300 had departed. Only 300, however, had been released because of successful completion of three years on parole. The remaining 3,000 who left had gone from the program to prison, or had disappeared, or died, or gotten out on writs of Habeas corpus or in other ways.11

The CRC program, moreover, locked up persons "in imminent danger of becoming addicted" as well as actual addicts. The Kramer-Bass study cited data indicating that a remarkably high proportion of the 300 alleged " successes" were not in fact heroin addicts and never had been. In a sample of the 300 "successes" selected at random for intensive study, more than 40 percent were "atypical." Some denied ever having used opiates. Some were primarily users of non-opiate drugs. Some had used heroin only occasionally, or onlv briefly, and so on.12 The Kramer-Bass study also cited reasons for anticipating that the relatively small proportion of "successes" emerging from the program--300 out of 3,300 departures was unlikely to improve as the program matured. Instead, more and more "residents" were likely to pile up inside the CRC as the years rolled by. Indeed, the 2,600 "residents" locked up in the institution in the spring of 1968 were already overcrowding it, and it became necessary soon thereafter to reduce the residence period in order to make room for more addicts. Meanwhile, narcotics addiction in California continues to be a major problem.*

- Dr. John C. Kramer wrote (1969): "Though the [California] program has been useful for a small proportion of those committed, for the majority it has proved to be merely an alternative to prison. The majority have entered a revolving system of admission-release-admission-release, and spend a majority of their commitment incarcerated in an institution which resembles a prison more Alan it does a hospital." 13

New York City and New York State have the most intense narcotics problem in the United States; it has been estimated that more than half of all American addicts reside there. For this and other reasons, which will become apparent below, several New York efforts to rehabilitate addicts deserve detailed attention.

One widely publicized New York program was launched in 1952 at Riverside Hospital on North Brother Island in the East River. Riverside's 140 beds, it was announced, were to be "devoted exclusively to the treatment, aftercare, and rehabilitation of adolescent narcotics addicts." It was to be very generously staffed-"14 full-time and 9 part-time physicians, 6 psychologists, 9 social workers, and 13 rehabilitation and educational personnel" 14-a total of 51 professionals plus guards and other employees for 141 addicts. It was realized, of course, that all the addicts in New York could not be as lavishly provided with care, including rehabilitation services and aftercare following release; but it was hoped that techniques could be devised at Riverside which might prove generally applicable. Some patients were admitted voluntarily; others were committed to Riverside by the courts. New York State put up a million dollars a year to fund the program.

After five years of Riverside, however, the New York City adolescent narcotics problem remained as acute as ever. Accordingly, in 1957, New York State Health Commissioner Herman Hilleboe, wishing to determine whether the state funds for Riverside were being wisely spent, asked Dr. Ray E. Trussell-then director of the Columbia University School of Public Health-to conduct an evaluation, in which all of the 247 adolescent addicts admitted to Riverside during the calendar year 1955 would be traced and their status determined.

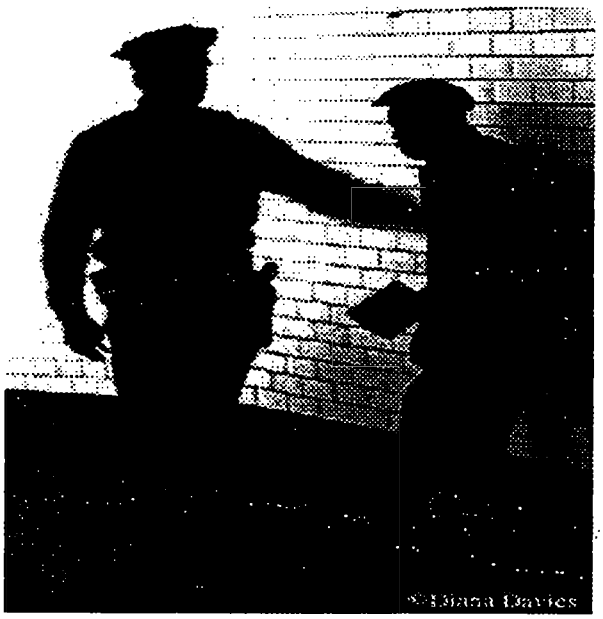
Tracing addicts in the world's largest city proved remarkably easy. "It turned out," Dr. Trussell explained, "that the best way to find these people was to keep an eye on hospital admissions and the admissions to penal institutions." 15 Eighty-six percent of the 247 addicts admitted to Riverside in 1955 were found again in prisons or hospitals-including Riverside Hospital-in 1958.

Dr. Trussell described the end results of the evaluation as "discouraging." Eleven of the 247 addicts were dead-a high death rate for an adolescent population. An additional 228 had been re-imprisoned, or re-hospitalized, or both, one or more times, following release from Riverside. Of the 247 addicts admitted in 1955, only eight remained alive, un-educated, imprisoned, and without hospitalized three years later.

Nor was that the worst of it. New York law, like California law and the law of several other states, provides for the incarceration not only of addicts but of persons in imminent danger of becoming addicted. What was most startling, Dr. Trussell reported, was the fact that all eight of the Riverside alumni who remained drug-free in 1958 "to a man swore that they had never been addicted; they had been caught in possession, they had been committed, they had put in their time and gone home, and that was the end of that episode so far as they were concerned." 16 Riverside Hospital records confirmed their non-addict status in seven of the eight cases. For patients actually addicted, the "success rate [was] zero." 17

In other words, heroin really is an addicting drug.

Having established with precision that the Riverside Hospital program had failed to rehabilitate even one out of 239 addicts, Dr. Trussell and his associates "had a behind-the-scenes meeting with city and state officials and various public leaders interested in the problem of addiction." 18 Those present agreed that "Riverside Hospital should be closed as an absolute failure." But now a phenomenon common in drug-addiction treatment programs appeared. just as Lexington continued to go through the motions of rehabilitating addicts for three decades despite mounting evidence that the failure rate exceeded 90 percent, so Riverside went right on functioning with a 100 percent failure rate. Eminent political figures who had taken credit for establishing



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Alcohol and barbiturates: Two ways of getting drunk

While the enormous usefulness of the barbiturates cannot be questioned, evidence increasingly accumulated during the 1930s and 1940s to indicate that, when misused, they are not so great an improvement over alcohol as had at first been supposed. Indeed, they resemble alcohol in almost all respects. You can get drunk on barbiturates (especially the short-acting kinds) as on alcohol. You can become addicted to barbiturates (especially the short-acting kinds) as to alcohol. A barbiturate addict suffers much the same delirium tremens when withdrawn from barbiturates as an alcoholic withdrawn from alcohol. And abrupt withdrawal may in both cases prove fatal. The parallel between the short-acting barbiturates and alcohol is particularly close, for alcohol is also a short-acting drug. (A long acting alcohol might be a safer drug.)

Among the several studies establishing the parallel between the barbiturates and alcohol, one small-scale experiment conducted at the United States Public Health Service Hospital in Lexington, Kentucky, is of special interest because of the many details it provides. Dr. Harris Isbell and his associates at Lexington isolated in a hospital research ward five prisoner volunteers serving sentences for narcotic law violations. The five were closely observed for a preliminary period, and subjected to a battery of neurological and psychological tests. Then each patient was given a large dose of a barbiturate.

The result was "a marked degree of intoxication," which resembled alcohol intoxication in almost all respects. In a word, the five men became dead drunk. "All patients had difficulty in thinking and deterioration in their ability in performing the psychological tests." They also showed neurological signs of alcohol intoxication, such as tremors and coordination.

As in the case with alcohol drunks, the reactions of the five patients drunk on barbiturates were far from uniform. Three of them passed out cold; the other two did not. Before passing out, two patients "became garrulous, boisterous, and silly"-the familiar behavior of many alcohol drunks. Two others became quiet and depressed, as also happens on alcohol. Just as an alcohol drunk often tries to pretend he is sober, moreover, these two "made desperate efforts to suppress signs of intoxication." The fifth patient, though he received as large a dose as the others, appeared to be little affected. In all cases, "signs of intoxication began to diminish within two hours after the drug was administered, and after four to five hours all clinical evidence of intoxication had disappeared."

The patients slept poorly that night, however, and "on the subsequent day they were nervous and tremulous and complained of anorexia [loss of appetite] and headache. They compared these [withdrawal] symptoms to a 'hangover' after an alcoholic debauch."

Having thus demonstrated that a barbiturate drunk is precisely like an alcohol drunk, including the subsequent hangover, Dr. Isbell and his associates next went on to reproduce by means of barbiturates all of the phases of chronic alcoholism. Each morning for more than three months, the five men were given a small "eye-opener" dose of a barbiturate before breakfast. Larger doses were then administered through the day-at 9 A.m. and at 2, 7, and 11 P.m.-much as some chronic alcoholics drink through the day. "Generally, the signs of intoxication were minimal early in the morning and increased throughout the day," the Isbell report noted, "reaching maximum intensity after the 11 P.m. dose" I-a finding equally common among some alcoholics.

"They neglected their appearance, became unkempt and dirty, did not shave, bathed infrequently, and allowed their living quarters to become filthy. They were content to wear clothes soiled with food which they had spilled. All patients were confused and had difficulty in performing simple tasks or in playing cards or dominoes."

During the preliminary drug-free period of the experiment, the five men had become good friends and had developed a spirit of camaraderie among themselves. While drunk on barbiturates, in contrast, they became "irritable and quarrelsome. They cursed one another, and at times even fought-all traits of the alcohol drunk.

At any cocktail party, one drunk may behave affectionately and garrulously while another becomes morose and a third becomes combative. Among these barbiturate drunks, too, "the effects on mood varied from day to day and from patient to patient. S-1, though occasionally euphoric, garrulous, and pleasant, was usually depressed, complained of various aches and pains, and continually sought increases in medication, although he was so intoxicated that he frequently could not walk ." 4 Bartenders, of course, are familiar

with the similar behavior of the drunk who, though barely able to stagger to the bar, pleads for just one more drink. Also like an alcoholic, patient S-1 "would weep over his wasted life and the state of his family."

Alcoholics often "swear off "-until it's time for the next drink; S-1 was like that, too. He "frequently asked to be released from the experiment, but would always change his mind within thirty minutes after missing a dose." In a word, he was addicted.

Patient P-3 was "frequently elated, hyperactive, and garrulous. At other times he was depressed, quiet and withdrawn and talked of the joys of death, but when pressed denied suicidal intentions. He continually attempted to obtain increases in medication. Although he always got along well with other patients when not intoxicated, he became involved in three fights and in a considerable number of cursing matches while taking pentobarbital."

Patient A-5, in contrast, "became even quieter and more withdrawn than he was before.... He sometimes spent days alone in his room and came out only for meals.... He had vague paranoid ideas"-like many alcoholics-"and stated the belief that the other patients did not like him and that the attendants were showing favor to them. He could not play dominoes without becoming involved in altercations. Some evidence suggestive of homosexual trends appeared.... He frequently made confused attempts to obtain increases in medication and seemed, as did S-1 and P-3, to be motivated by a desire to become completely unconscious."

The remaining two patients "showed less pronounced changes in behavior. They continued to maintain good relationships with the other patients and with the attendants, and their personal appearance deteriorated less... The general picture in both these men was that of a person who was drunk and enjoyed it.' Psychological and neurological test results closely paralleled the results of tests on chronic alcoholics; the neurological signs increased throughout the day, so that by 11 P.M. "all the patients would be staggering and unable to walk except by sliding along the walls. In spite of close supervision, they occasionally fell and were injured.

Similar falls and injuries are frequent among alcoholics. "The patients also tended to be more boisterous and quarrelsome at night, and most fights occurred at that time.... Great care had to be exercised to prevent patients from smoking in bed and setting fires"-a major hazard also among alcoholics.

As in the case of alcoholics, the amount of barbiturate needed to keep these barbiturate addicts drunk "varied widely from subject to subject." ' it was following withdrawal of barbiturate, however, that the parallel between that drug and alcohol was most impressively demonstrated. When an alcoholic who has been continuously drunk for days or weeks is abruptly deprived of his alcohol, he goes through a series of well-defined stages. At first he seems to be sobering up normally. Then anxiety and weakness set in, along with a gross tremor-"the shakes." The patient eats little but vomits often. A more dangerous stage follows, characterized by "rum fits"-convulsions like those seen in epilepsy.

Then comes delirium tremens-a life-threatening condition characterized by delusions, hallucinations, and other signs of psychosis as well as physical signs (such as profuse sweating and, in some cases, high fever). These five barbiturate addicts went through precisely this sequence of changes when their drug was withdrawn. Dr. Isbell and his associates, of course, had had long experience with morphine and heroin addicts at the Public Health Service Hospital in Lexington. They were therefore in a position to compare these barbiturate phenomena with the comparable opiate phenomena.

The manifestations of chronic barbiturate intoxication are, in most ways, much more serious than those of addiction to morphine [they noted]. Morphine causes much less impairment of mental ability and emotional control and produces no motor in coordination. Furthermore, such impairment as does occur becomes less as tolerance to morphine develops, and withdrawal of morphine is much less dangerous than is withdrawal of barbiturates.

The Isbell group also compared the barbiturates and alcohol. "It is obvious," they concluded, "that chronic barbiturate intoxication is a dangerous and undesirable condition, which is very similar to chronic alcoholism"; and they added, "The similarity of the barbiturate withdrawal syndrome to alcoholic delirium tremens is striking." Readers were left to draw the two corollaries for themselves-that alcoholism is in most respects much more serious than morphine addiction; and that withdrawal of alcohol is even more dangerous than morphine withdrawal.

Current scientific opinion confirms the findings of earlier decades. Thus Dr. Jerome H. Jaffe notes in Goodman and Gilman's textbook (1970):

. . . The subjective effects of barbiturates and sedatives . . . are similar to those of alcohol. [As with alcohol], the effects vary considerably with the dose, the situation, and the personality of the user.... The patterns of abuse are as varied as those for alcohol and range from infrequent sprees of gross intoxication, lasting a few days, to the prolonged, compulsive, dailv use of huge quantities and a preoccupation with securing and maintaining adequate supplies.

In addition to this evidence demonstrating the parallel between barbiturates and alcohol, there is even more startling evidence to indicate that these two substances are in fact producing many of the same effects -that the barbiturates might be labeled a "solid alcohol" and alcohol classed as a "liquid barbiturate."

A man who drinks increasing quantities of alcohol, for example, becomes tolerant to alcohol effects-but he simultaneously develops cross-tolerance for barbiturate effects as well, and can tolerate an enormous dose of a barbiturate the very first time he tries the drug. The same is true in reverse; as the barbiturate addict increases his dose, be simultaneously

achieves cross-tolerance for alcohol as well as barbiturates, and can take enormous doses. Some alcoholics under pressure to give up alcohol do give it up completely, without any of the usual suffering, "shakes," "rum fits," and delirium tremens-by substituting barbiturates for alcohol. (Some who make the changeover report that they prefer the barbiturates.) Many addicts use alcohol and barbiturates interchangeably, depending on which is cheaper or more conveniently available at the moment. Many use the two drugs at the same time. Simultaneous use is dangerous, however; for with either drug, there is only a narrow margin between the maximum dose that an addict can manage and the lethal dose-and it is harder to gauge the dose when both drugs are taken together.

Finally, the barbiturate effect of alcohol and the alcohol effect of the barbiturates is demonstrated during delirium tremens; either drug can relieve delirium tremens, whether caused by the same drug or by its twin. Indeed, one of the standard treatments for alcohol delirium tremens is to place the patient on intoxicating doses of a barbiturate, and then slowly to taper off the dosage. Drugs of another closely related group, the minor tranquilizers, are also now used for this purpose.

There are also significant practical differences between alcohol and the barbiturates. The latter are less likely to lead to serious malnutrition and accompanying neurological damage , and are less damaging to the gastrointestinal system. Alcohol in the form of light wines and beer is less concentrated, so that the imbibing of a moderate series of doses can be spread over a period of time. An overdose of alcohol is toxic and sometimes lethal; but it is much easier to pop a whole handful of pills than to down a quart of whiskey. Hence, death from barbiturate overdose (or from a combination of alcohol and barbiturate), either accidental or with suicidal intent, is more common. Despite these and other differences, some in favor of alcohol and some the barbiturates, the close parallel between these drugs might be expected to lead to similar moral attitudes toward them-and to similar laws and national policies.

In fact, however, society takes a very different stance with respect to these twin drugs. Alcohol is treated as a non drug; it is on sale in multi dose bottles at some 40,000 liquor stores and in countless other outlets as well; it is freely sold to those "of age," in saloons, taverns, cocktail lounges, nightclubs, roadhouses, and even ordinary family restaurants; and more than $250,000,000 a year is spent on advertising alcohol.

The barbiturates, in contrast, are legally salable only on prescription in pharmacies; other sales are severely punishable criminal offenses. It is a curious fact, indeed, that Americans today are bombarded with advertising urging them to buy a liquid that, if secured without a prescription in tablet or capsule form, could lead to imprisonment for both seller and buyer.

The Consumers Union Report on Licit and Illicit Drugs by Edward M. Brecher and the Editors of Consumer Reports Magazine, 1972

Chapter 35. Cocaine

The chief active ingredient in coca leaves, the alkaloid cocaine, was isolated in pure form in 1844.1 Little use was made of it in Europe, however, until 1883, when a German army physician, Dr. Theodor Aschenbrandt, secured a supply of pure cocaine from the pharmaceutical firm of Merck and issued it to Bavarian soldiers during their autumn maneuvers. He reported beneficial effects on their ability to endure fatigue.

Among those who read Dr. Aschenbrandt's account with fascination was a poverty-stricken twenty-eight-year-old Viennese neurologist, Dr. Sigmund Freud (whose subsequent ordeal with nicotine was recounted in Chapter 24). Young Freud at the time was suffering from depression, chronic fatigue, and other neurotic symptoms. "I have been reading about cocaine, the essential constituent of coca leaves, which some Indian tribes chew to enable them to resist privations and hardships," Freud wrote to his fianc6e, Martha Bernays, on April 21, 1884. "I am procuring some myself and will try it with cases of heart disease and also of nervous exhaustion. . . .`3 The account of Freud's experiences which follows is drawn largely from the three-volume Life and Work of Sigmund Freud, by Ernest Jones.

Freud "tried the effect of a twentieth of a gram [50 milligrams] and found it turned the bad mood he was in into cheerfulness, giving him the feeling of having dined well 'so that there is nothing at all one need bother about,' but without robbing him of any energy for exercise or work."

In addition to taking cocaine himself, Freud offered some to his friend and associate, Dr. Ernst von Flcischl-Marxow, who was suffering from an exceedingly painful disease of the nervous system (which was later to prove fatal), and who was addicted to morphine. Freud also prescribed cocaine for a patient with gastric catarrh. The initial results in all three cases were favorable. Freud decided cocaine was "a magical drug," and he wrote his fiancée, Martha:

If it goes well I will write an essay on it and I expect it will win its place in therapeutics by the side of morphium and superior to it. I have other hopes and intentions about it. I take very small doses of it regularly against depression and against indigestion, and with the most brilliant success.... In short it is only now that I feel I am a doctor, since I have helped one patient and hope to help more. If things go on in this way we need have no concern about being able to come together and to stay in Vienna.

Freud even sent some of his precious cocaine to Martha, "to make her strong and give her cheeks a red color." Indeed, Dr. Jones writes, "he pressed it on his friends and colleagues, both for themselves and their patients; he gave it to his sisters. In short, looked at from the vantage point of our present knowledge, he was rapidly becoming a public menace."

In a subsequent letter to Martha, Freud wrote more on his personal experience with cocaine:

Woe to you, my Princess, when I come. I will kiss you quite red and feed you till you are plump. And if you are froward you shall see who is the stronger, a gentle little girl who doesn't eat enough or a big wild man who has cocaine in his body.
In my last severe depression I took coca again and a small dose lifted me to the heights in a wonderful fashion. I am just now busy collecting the literature for a song of praise to this magical substance.

Freud's haste in publishing his findings may astonish twentieth-century readers. On April 21, 1884, he was still only planning to secure some cocaine. On June 18, his essay was completed; and the "Song of Praise" to cocaine was published in the July 1884 issue of the Centralblatt fur die gesammte Therapie.
This essay, Dr. Jones writes, had "a tone that never recurred in Freud's writings, a remarkable combination of objectivity with a personal warmth as if he were in love with the content itself. He used expressions uncommon in a scientific paper such as 'the most gorgeous excitement' that animals display after an injection of cocaine, and administering an 'offering' of it rather than a 'dose'; he heatedly rebuffed the 'slander' that had been published about this precious drug. This artistic presentation must have contributed much to the interest the essay aroused in Viennese and other medical circles. . . . He even gave an account of the religious observances connected with its use, and mentioned the mythical saga of how Manco Capac, the Royal Son of the Sun-God, had sent it as 'a gift from the gods to satisfy the hungry, fortify the weary, and make the unfortunate forget their sorrows.' "

More to the point, Freud described in detail the effects of small doses of cocaine on his own depression. These included "exhilaration. and lasting euphoria, which in no way differs from the normal euphoria of the healthy

person. . . . You perceive an increase of self-control and possess more vitality and capacity for work. . . . In other words, you are simply normal, and it is soon hard to believe that you are under the influence of any drug.... Long intensive mental or physical work is performed without any fatigue.... This result is enjoyed without any of the unpleasant after-effects that follow exhilaration brought about by alcohol. . . . Absolutely no craving for the further use of cocaine appears after the first, or even after repeated taking of the drug; one feels rather a certain curious aversion to it."

Cocaine, Freud concluded, was useful for "those functional states comprised under the name neurasthenia" "-Freud at this time had diagnosed his own depressions as neurasthenic-as well as for indigestion and for the withdrawal of morphine. Freud also sought to inject cocaine directly into the area of a nerve to block intractable pain. In this he failed, but others succeeded;' and until better agents became available, cocaine was often used as local anesthesia for surgery. Some of Freud's findings on cocaine as a psychoactive drug were amply confirmed by subsequent research. "The subjective effects of cocaine include an elevation of mood that often reaches proportions of euphoric excitement," Dr. Jaffe reported in Goodman and Gilman's textbook (1965). "It produces a marked decrease in hunger, an indifference to pain, and is reputed to be the most potent anti fatigue agent known. The user enjoys a feeling of great muscular strength and increased mental capacity and greatly overestimates his capabilities. The euphoria is accompanied by generalized sympathetic stimulation. As is the case with amphetamine, a disturbed personality is not a prerequisite for cocaine-induced euphoria, and the drug is quite effective in relatively normal personalities."

Freud's experience, however, proved to be only part of the story. In July 1885, a German authority on morphine addiction named Erlenmever launched the first of a series of attacks on cocaine as an addicting drug. In January 1886 Freud's friend Obersteiner, who had at first favored cocaine, reported that it produced severe mental disturbances similar to those seen in delirium tremens. Other attacks soon followed; and Freud himself was subjected to "grave reproaches." 12 Freud continued to praise cocaine as late as July 1887, when he published a final defense of the drug. But soon thereafter he discontinued all use of it both personally and professionally. Despite the fact that he had been taking cocaine periodically over a three-year span, he appears to have had no difficulty in stopping. His abandonment of cocaine was no doubt influenced in large part by the experience of Dr. von Fleischl-Marxow, the patient with whom Freud had shared his initial gram of cocaine.

* Among those who succeeded, , was the voting American surgeon, Dr. W. S. Halsted. Fleischl suffered from multiple tumors of various peripheral nerves - netiromata-which gave him excruciating pain. He took morphine for this pain. At

first Freud's cocaine proved a -welcome substitute for the morphine-but Fleischl found it necessary to escalate his cocaine dose.

After a year on cocaine he was taking a full gram of it daily'-twenty times the dose Freud himself took from time to time. Indeed, Freud noted, Fleischl bad spent $428 for a three-month supply of cocaine, an enormous sum in Vienna in those days. On June 8, 1885, Dr. Jones adds, "Freud wrote that the frightful doses had harmed Fleischl greatly and, although he kept sending Martha cocaine, he warned her against acquiring the habit." Thereafter Fleischl developed' a full-fledged cocaine psychosis, "Nvith white snakes creeping over his skin."

Freud and other physician friends ministered Fleischl faithfully, often throughout the long nights, but to little avail. In June 1885 Freud estimated that Fleischl could live six more months at most; he actually survived for six more pain wracked years.

Nor was Fleischl's experience unique; subsequent observations were to reveal that repeated use of large doses of cocaine produces a characteristic paranoid psychosis in all or almost all users, and that the tendency to overuse is widespread. A peculiar characteristic of this psychosis is "fornication-the hallucination that ants, or insects, or (as in Fleischl's case) snakes, are crawling along the skin or under it.

Why was Freud, unlike his friend Fleischl, able to use modest doses of cocaine-30 to 50 milligrams injected tinder the skin-from time to time for three years without developing either a craving for the drug or a need to escalate the dose? At least three alternative explanations are available. Dr. Jones, a psychoanalyst, believed that it requires an "addictive personality" to establish an addiction; Tricking an addictive personality, he declares, Freud didn't become a cocaine addict. (He did, however, become addicted to cigars).

The other two explanations are pharmacological. One holds that there must be some biochemical difference-perhaps a difference in enzymes-between people like Freud who can take a particular addicting drug without becoming addicted and people like Fleiscbl who escalate the dose and become addicted. This hypothetical difference in enzymes may (or may not) be hereditary. The third explanation relates the addiction (or lack of it) to dosages and frequency of use. Because Freud took cocaine only occasionally, according to this theory, be had no need to escalate his dose. And because lie did not escalate the dose, he did not become addicted. Some other explanation, of course, may ultimately prove true.

By 1840, the addicting and psychosis-producing nature of cocaine was well understood in medical circles; yet for another twenty years it does not appear to have occurred to many people to demand a late against the drug.

In the United States, cocaine was widely used not only in Coca-Cola but also in "tonics" and other patent medicines, including very popular "catarrh cures"-for, like the amphetamines, cocaine has the effect of reducing mucous membrane swelling and thus enlarging the nasal and bronchial passages. This property no doubt first gave users the idea of sniffing cocaine, a common form of cocaine use even today. "Most of the cases of the cocaine habit have been admittedly created by the so-called catarrh cures," Dr. Charles B. Towns wrote in Century Magazine in. 1912, "and these contain only two to four percent of cocaine.* In the end, the snuffer of catarrh powders comes to demand undiluted cocaine."

*** Dr. Charles B. Towns wrote (1912): "When in overseer in the South will deliberately put cocaine into the rations of his Negro laborers in order to get more work out of them to meet a sudden emergency, it is time to have some policy of accounting for the sale of a drug like cocaine."**

* "Street cocaine" sold on the New York black market in 1970 was reported to contain about 6 percent pure cocaine.

Cocaine addiction differs from opiate addiction, and from alcohol and barbiturate addiction, in at least two respects. A cocaine user, even after prolonged use of large doses, does not, if deprived of his drug, suffer from a dramatic withdrawal crisis like alcoholic delirium tremens or like the opiate withdrawal syndrome. The physical effects of cocaine withdrawal are minor. This has led many authorities, mistakenly, to classify cocaine as a nonaddicting drug. However, cocaine withdrawal is characterized by a profound psychological manifestation-depression-for which cocaine itself appears to the user to be the only remedy; cocaine addiction in this respect resembles tobacco addiction more closely than it resembles opiate addiction or alcoholism. The compulsion to resume cocaine is very strong.

Moreover, cocaine addiction can lead to a severe psychosis while the user is still on the drug. This is in contradistinction to the opiate withdrawal syndrome and to the delirium tremens of alcoholism or barbiturate addiction, which set in hours or days after the drug is withdrawn.

Decades ago, cocaine users discovered that a mixture of cocaine and morphine or heroin relieves the excess agitation and tension produced by large doses of pure cocaine. The users of morphine and heroin similarly discovered that the mixture increases both the "bang" or "rush" or "flash" and the mood elevation produced by their favorite drug. The combination came to be known as the "speedball," and

it has long been popular among some addicts in Britain, the United States, and elsewhere.

Since 1914, the possession, sale, and giving away of cocaine have been subject to the same dire federal penalties as those governing morphine and heroin; and most state laws similarly identify cocaine as a "narcotic."

During the 1940s, 1950s, and most of the 1960s, the smuggiing of cocaine into the United States was curtailed and the black market in cocaine was relatively small. The reduced use of cocaine, however, can hardly be attributed, even in part, to law-enforcement efforts. Neither was it the result of pharmacological research. Cocaine was replaced by a new group of synthetic drugs, the amphetamines, which were available far more cheaply than cocaine after 1932, and which had certain other advantages over the natural imported product. Latc in the 1960s, when narcotics law-enforcement agencies began cracking down heavily on the amphetamine black market, cocaine smuggling and cocaine use enjoyed a renaissance.

The Consumers Union Report on Licit and Illicit Drugs

by Edward M. Brecher and the Editors of Consumer Reports Magazine, 1972

55. Marijuana and alcohol prohibition

It was a change in the laws rather than a change in the drug or in human nature that stimulated the large-scale marketing of marijuana for recreational use in the United States. Not until the Eighteenth Amendment and the Volstead Act of 1920 raised the price of alcoholic beverages and made them less convenient to secure and inferior in quality did a substantial commercial trade in marijuana for recreational use spring up.

Evidence for such a trade comes from New York City, where marijuana "tea pads" were established about 1920. They resembled opium dens or speakeasies except that prices were very low; a man could get high for a quarter on marijuana smoked in the pad, or for even less if he bought the marijuana at the door and took it away to smoke. Most of the marijuana, it was said, was harvested from supplies growing wild on Staten Island or in New Jersey and other nearby states; marijuana and hashish imported from North Africa were more potent and cost more. These tea pads were tolerated by the city, much as alcohol speakeasies were tolerated. By the 1930s there were said to be 500 of them in New York City alone.1

In 1926 the New Orleans Item and Morning Tribune, two newspapers under common ownership, published highly sensational exposes of the "menace" of marijuana.2 They reported that it was coming into New Orleans from Havana, Tampico, and Vera Cruz in large quantities, plus smaller amounts from Texas. "In one day, ten sailors were followed from the time they left their ships until they delivered their respective packages of the drug to a particular block in the Vieux Carre."3 The sailors, it was said, bought marijuana in the Mexican ports for $10 or $12 per kilogram (2.2 pounds) and sold it in the Vieux Carre for $35 to $50.4 This was far more profitable than smuggling a comparable weight of whiskey.

Much of the smuggled marijuana was smoked in New Orleans; but some, it was said, was shipped-up the Mississippi and "found its way as far north as Cleveland, Ohio, where a well-known physician said it was smoked in one of the exclusive men's clubs."
In New Orleans, the reporters in 1926 laid particular stress on the smoking of marijuana by children. "It was definitely ascertained that school children of 44 schools (only a few of these were high schools) were smoking 'mootas.' Verifications came in by the hundreds from harassed parents, teachers, neighborhood pastors, priests, welfare workers and club women. . . . The Waif's Home, at this time, was reputedly full of children, both white and colored, who had been brought in under the influence of the drug. Marijuana cigarettes could be bought almost as readily as sandwiches. Their cost was two for a quarter. The

children solved the problem of cost by pooling pennies among the members of a group and then passing the cigarettes from one to another, all the puffs being carefully counted." A Louisiana law passed in 1927, after the newspaper expose, provided a maximum penalty of a $500 fine or six months' imprisonment for possession or sale of marijuana. There followed "a wholesale arrest of more than 150 persons. Approximately one hundred underworld dives, soft drink establishments, night clubs, grocery stores, and private homes were searched in the police raids. Addicts, hardened criminals, gangsters, women of the streets, sailors of all nationalities, bootleggers, boys and girls-many flashily dressed in silks and furs, others in working clothes all were rounded up in the net which Captain Smith and his squad had set."

- The penalties were later escalated to include thirty years at hard labor or the death sentence for sale of marijuana to anyone under twenty-one years of age (first offense). We have found no record, however, of the actual imposition of the death sentence in a United States marijuana case.

The newspaper investigation, the new law, and the heavily publicized police roundups did not, however, accomplish their purpose. On the contrary, according to Commissioner of Public Safety Frank Gomila, during the next few years New Orleans "experienced a crime wave which unquestionably was greatly aggravated by the influence of this drug habit. Payroll and bank guards were doubled, but this did not prevent some of the most spectacular hold-ups in the history of the city. Youngsters known to be 'muggle-heads' fortified themselves with the narcotic and proceeded to shoot down police, bank clerks and casual bystanders. Mr. Eugene Stanley, at that time District Attorney, declared that many of the crimes in New Orleans and the South were thus committed by criminals who relied on the drug to give them a false courage and freedom from restraint. Dr. George Roeling, Coroner, reported that of 450 prisoners investigated, 125 were confirmed users of marihuana. Mr. W. B. Graham, State Narcotic Officer, declared in 1936 that 60 percent of the crimes committed in New Orleans were by marihuana users."

Intensive patrolling of the New Orleans harbor tended to curb imports; but Louisianans were little inconvenienced by the smuggling curbs; they simply began to grow their own marijuana. "The first large growing crop in the city was found in 1930 and its value estimated at $35,000 to $50,000.... In 1936 about 1,200 pounds of bulk weed were seized along with considerable quantities of cigarettes. On one farm, 5 1/2 tons were destroyed and other farms yielded cultivated areas of about 10 acres....

One resident of the city was found growing 100 large plants in his backyard." 10 The net effect of eleven years of vigorous law enforcement was summed up by Commissioner Gomila in 1938: "Cigarettes are hard to get and arc selling at 30 to 40 cents apiece, which is a relatively high price and a particularly good indication of the effectiveness of the present control." 11 Marijuana smoking, in short, had become endemic in New Orleans-and remains endemic today. What years of law enforcement had accomplished was to raise the price from two for 25 cents to 30 cents or 40 cents apiece-and even this increase might be attributable in part to inflation.

In Colorado, the Denver News launched a similar series of sensational marijuana expos6s following the pattern set in New Orleans.12 Mexican laborers imported to till the Colorado beet-sugar fields, it seems, had found Prohibition alcohol very expensive and so had resorted instead to marijuana, bringing their supplies north with them. A Colorado law against marijuana was duly passed in 1929.

These sensational newspaper accounts and early efforts to outlaw marijuana should not, however, be taken as evidence that marijuana smoking was in fact widespread. In 1931 the United States Treasury Department, then responsible for enforcing both the federal anti narcotics and the federal anti alcohol laws, indicated that the marijuana exposes in the newspapers were quite possibly exaggerated:

> A great deal of public interest has been aroused by newspaper articles appearing from time to time on the evils of the abuse of marihuana, or Indian hemp, and more attention has been focused on specific cases reported of the abuse of the drug than would otherwise have been the case. This publicity tends to magnify the extent of the evil and lends color to an inference that there is an alarming spread of the improper use of the drug, whereas the actual increase in such use may not have been inordinately large.

Work with a partner to arrive at Consensus !

Identify areas where you both are deadlocked.

Decide which one of you will give a report to the entire group.

LEVELS OF RISK

- Define the concept of risk ?
- How do you determine risk ?
- How do you determine a reasonable risk ?

1.0 personal vulnerability
1.1 family impact
1.2 societal norms

- How important is it that other people accept your decisions about risk ?
- Identify three risky behaviors that you have grown accustomed to :

a) name the behavior
b) identify a purpose the behavior has in your life
c) describe actions or conditions which reduce the "risks" involved
d) justify future usage of the discussed risk behavior !

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Harvard AIDS review

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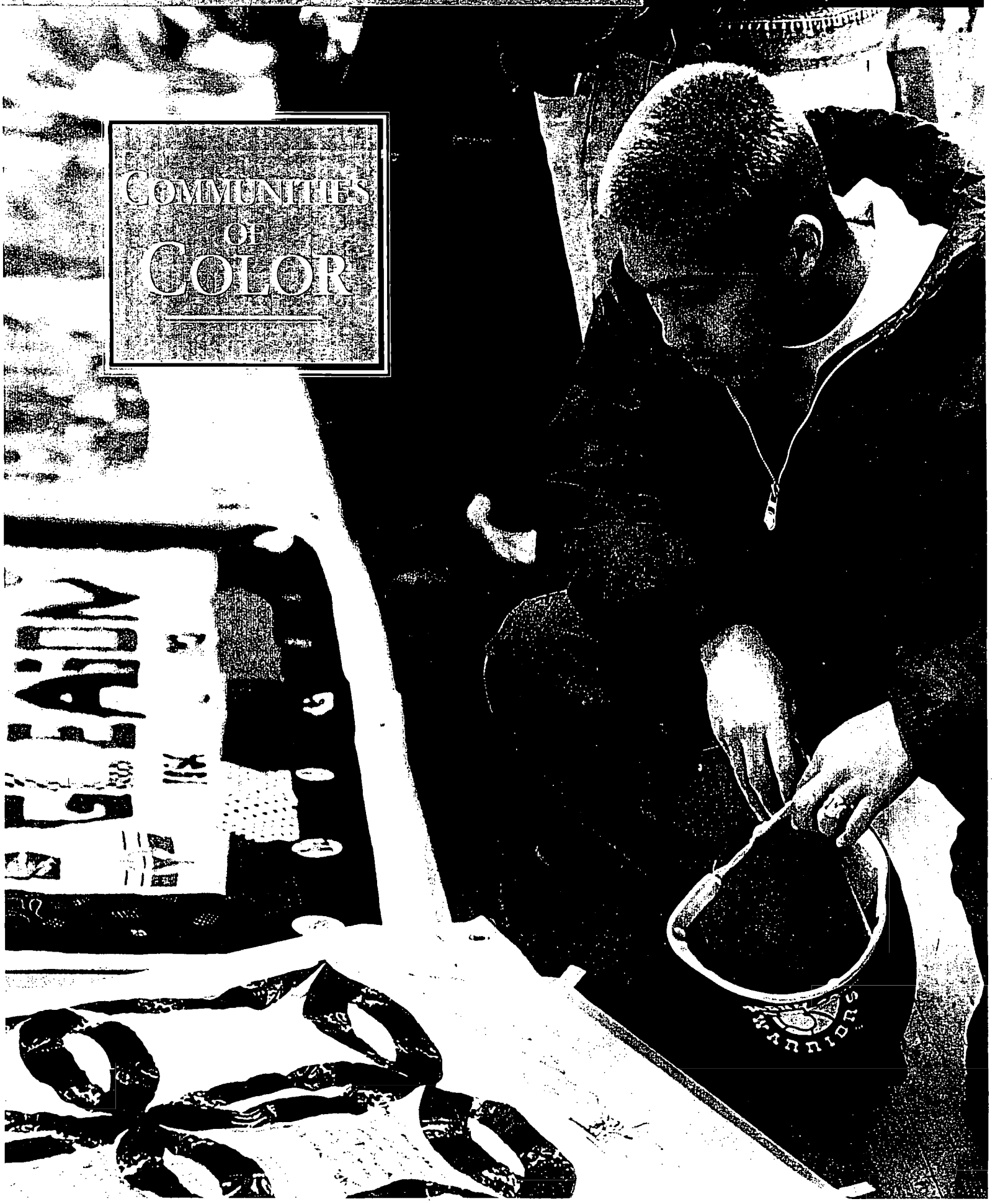
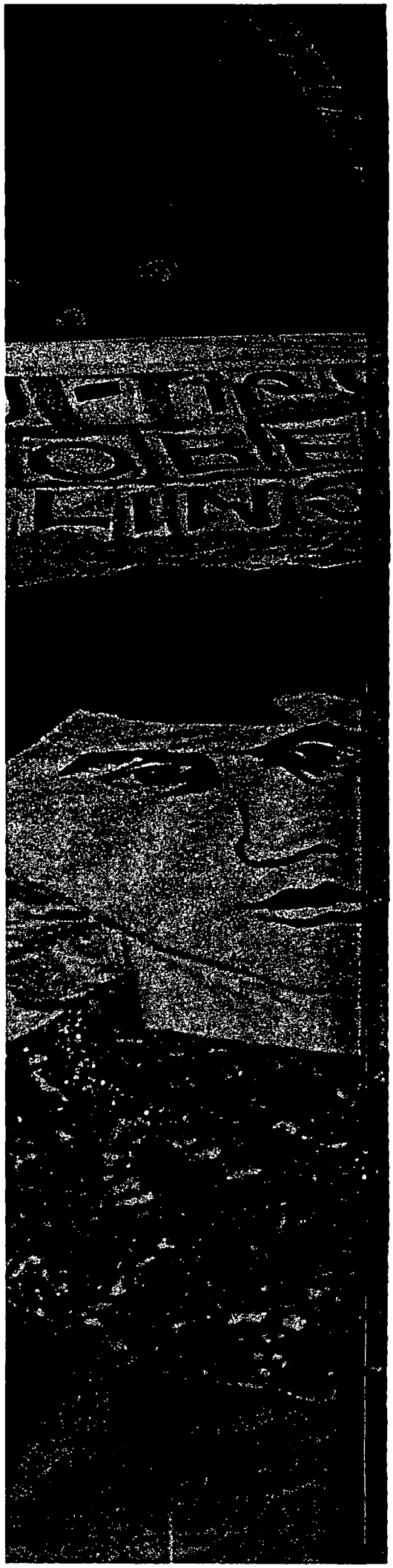
COMMUNITIES OF COLOR



HIV AMONG AFRICAN AMERICANS



EACH DAY, AFRICAN AMERICANS ARE STITCHING NEW PANELS OF THE AIDS MEMORIAL QUILT FOR THEIR LOVED ONES. African Americans—who compose 13 percent of the U.S. population—now account for 40 percent of all people with AIDS in the United States.

AFRICAN AMERICANS ARE BEING DIAGNOSED WITH AIDS AT A RATE SIX TIMES FASTER THAN that of whites, a proportional disparity that increases each year. Yet interpreting this disparity in simple numeric terms can create a distorted view, for race often shrouds the complex knot of medical, social, and economic risk factors that ties the African American community to AIDS.

"Looking at AIDS as a 'black' problem sometimes obscures the issues," says Alvin Poussaint, professor of psychiatry at Harvard Medical School. Poussaint believes that while studying the intersections between AIDS and race may be useful, the questions themselves need to be reevaluated. "What would these data look like if we were to control for factors such as poverty?" he asks. "It may be more apt to compare AIDS rates in terms of socioeconomic class."

"We don't want to talk about race as a risk factor so much that it implies that membership in a racial group puts you at risk of HIV."

Robert Fullilove, associate dean at the Columbia University School of Public Health, agrees. "Not all African Americans are at higher risk for HIV," he says. "We don't want to talk about race as a risk factor so much that it implies that membership in a racial group puts you at risk of HIV."

Legacies of Injustice

"A better model for examining what's going on with HIV in communities of color is not related to race," Fullilove adds, "but to social realities that are the legacies of slavery and segregation." Understanding the HIV epidemic among African Americans requires an examination of how factors such as

Images from a recent Massachusetts Department of Public Health AIDS awareness campaign can be seen on billboards, subway signs, and bumper stickers. This campaign targets African American men.

poverty, denial, and the constant thread of racism combine with the virus to kill.

As with members of all other racial and ethnic groups, African Americans can be found at every point on the socioeconomic spectrum. Ethnographic studies conducted over the past thirty years in poorer communities of color, however, have demonstrated several trends that have resulted in limited education and employment opportunities, including a loss of jobs, the expansion of an underground economy, and the increased availability of drugs. As a result, individuals living in these communities often face a lack of choices that can lead to behaviors that make them vulnerable to HIV.

"When a virus doesn't make you sick for ten or fifteen years, it gets placed on the back burner," Fullilove says. "It's not that people don't know about HIV or aren't aware of the dangers, it's just that they have to prioritize their needs. Some of these same neighborhoods often have increased rates of violent crime and drug use. If you're worried about being hit by a bullet tomorrow, why worry about a virus that won't kill you for another fifteen years?"

While noting that Americans tend to use drugs at fairly constant rates across all demographic categories, Fullilove observes that the kinds of drugs used vary across places and populations. In the inner city, injection drugs are prevalent, and, Fullilove says, "where there is exposure to injection drugs, there is likely to be use."

In many African American communities, such use has led to high rates of HIV transmission. "We need to examine the dynamics in a community that make all this possible," Fullilove says. "We need to look at the intersection of who you are, where you are, and what you do, and deal with these three things in the aggregate. This epidemic is not about skin color."

Distrust and Denial

What the epidemic *is* about—to a large degree—is an ever-rising number of infections. More than half of all children who have been diagnosed with AIDS in the United States are African American. By the end of 1995, nearly 175,000 African Americans had been diagnosed with AIDS. The latest U.S. data suggest that more African Americans are now infected with HIV than all other racial and ethnic groups combined.

According to the Centers for Disease Control and Prevention, African American men tend to be infected through sex with another man or through injection drug use, while African American women often acquire the virus through injection drug use or through sex with an infected man.

The risk of HIV infection stems from more than the dynamics of impoverished communities. African Americans are also at risk because of a history of distrust and denial. "People keep expecting us to act as if we are the dominant culture, in total control," says Wilbert Jordan, director of the AIDS clinic at King/Drew Medical Center in Los Angeles. "But we aren't."

For African Americans, the AIDS epidemic began with a loss of trust. In 1980, the 300,000 Haitians fleeing a repressive political regime were accused of bringing HIV into the United States. The Centers for Disease Control and Prevention designated all Haitians as high risk and included them in the "4-H club" along with homosexuals, heroin users, and hemophiliacs. For these

"The epidemic has settled in so-called throwaway communities. These are the same communities that the country seems to refuse to see as worthy of respect, support, or resources."

individuals, the stigma derived not from their risk behaviors, but solely from their membership in a group.

This injustice against Haitians was the latest example in a long history of abuse of medical power against African Americans. Between 1932 and 1972, for example, the U.S. Public Health Service denied treatment to approximately 400 poor, black men with syphilis in Macon County, Alabama—even after penicillin became the standard therapy in 1954. This Tuskegee Syphilis Study is still often cited to lend credence to rumors that AIDS is part of a plot to wipe out African Americans; in a 1991 survey published in the *American Journal of Public Health*, 35 percent of African Americans queried said they believed that AIDS is a form of genocide.

"Calling blacks 'paranoid' is unfair because of the history of medical experimentation in this country, and also because this is an issue of trust," Jordan says. Poussaint concurs that many African Americans have suffered—and continue to do so—within the mainstream medical establishment. At the same time, however, he says, "Community members who subscribe to conspiracy theories may use those beliefs as tools to avoid the responsibility of taking action against HIV infection."

Distrust of the medical establishment is not the only root of denial; the perception of AIDS as a disease of white homosexual men also helped denial take hold. Ten years ago, Belynda Dunn's fiancé suddenly left town without a word. "When I found out he later died of AIDS, I was shocked," says Dunn, African American education specialist at Boston's AIDS Action Committee. "He had been using injection drugs. I have no doubt he loved me, but this was 1986, when AIDS was still really stigmatized as a gay disease. Even today, denial remains a major factor among African Americans."

Janet Mitchell, director of obstetrics and fetal medicine at Interfaith Medical Center in Brooklyn, offers a slightly different perspective, suggesting that the African American community does not so much deny the epidemic as respond to it away from the public eye. "It's not actual denial. It's just that, in our culture, you don't air dirty laundry in newspapers," she says. "We don't resolve issues with everything hanging out in editorials. This is a cultural issue that gets misinterpreted. Among ourselves, where there is trust, we acknowledge AIDS."

Mitchell also emphasizes that AIDS is a powerful issue for African Americans across the full socioeconomic spectrum. "It's not just the poor and underclass who have been affected," she says. "We've all been personally touched by AIDS. When I lecture around the country, professionals always come up at the end of my talks to tell me that they're dealing with HIV infection, whether in

When Belynda Dunn learned she had HIV, she was [illegible] told [illegible]

Creating a community with each other, members of the People Living with HIV/AIDS Caucus of the National Black Lesbian and Gay Health Coalition meet at the coalition's annual conference.

themselves, their families, or their friends. This epidemic has become personal for almost everyone I know."

The Thread of Racism

Fullilove believes that running through each issue related to the epidemic among African Americans—whether persistent poverty, or distrust of the medical establishment—is the thread of racism. He contends that racism is the reason that the nation has not taken greater action against the epidemic among communities of color. "The epidemic has settled in so-called throwaway communities," he says. "These are the same communities that the country seems to refuse to see as worthy of respect, support, or resources."

Poussaint concurs: "One issue for African Americans is whether there is sufficient progressive leadership in white-controlled organizations. Are they concerned enough about blacks with AIDS? Or are they more concerned about black issues that affect whites, such as black crime or drug abuse?"

The Community Responds

Within the African American community itself, the AIDS epidemic has led to a search for leadership. Among the organizations looked to most often is the black church. "More than anything else, the church is the institution that has a history of being responsive in dire times," Fullilove says. "But for now, AIDS is still being dealt with poorly."

One study among African American ministers in New York City found that some were reluctant to address the epidemic because they identified AIDS with homosexuality. "The inability of these ministers to raise HIV awareness in their communities is related to the church's age-old dilemma between serving those in need and recognizing homosexual behavior," Fullilove says.

Fullilove thinks that the opinions of such religious leaders are changing, as they confront the harsh reality of the epidemic. "The black church has had to meet the issue head on, because AIDS has refused to go away," he says. "There have been just too many funerals for it to be ignored."

Others believe that the church has responded well. Belynda Dunn, for one, says she is a living testament to its power. Upon learning of her own infection several years after her fiancé died, Dunn says, "I was devastated. I appeared as a broken-down shell of a woman with no job, no home, no clothes. The church supported me and helped me find a home."

With the church to support her, Dunn decided not to remain silent about being infected. "I knew I couldn't be the only one who had this story to tell," she says. "I felt I had to be there for other people." Dunn, like many others, is working to untangle the complex knot that has tied the African American community to HIV. ♥

—Harriet Washington is the editor of The Harvard Journal of Minority Public Health.

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