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Winning the Drug War: New Challenges For the 1990s

Edited by Jeffrey A. Eisenach

The Heritage Foundation

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Introduction

Jeffrey A. Eisenach and Edwin Meese III

There is no single, easy solution to the problem of illegal drug use. Over the course of the two decades that America has been fighting the current drug epidemic, literally thousands of different approaches have been taken. Some of those approaches have produced results, others have not. We have been successful in fighting parts of the problem, even as we have failed to solve it in the aggregate. And, some solutions have worked for a time but, as the problem itself has changed, the old solutions have outlived their usefulness.

That is the situation we find ourselves in today. We have developed solutions to some elements of the drug problem, and those solutions have, to a much greater extent than most people recognize, succeeded in reducing the overall use of drugs in America. Yet, drugs remain a major problem in some areas of the country and among some population groups. The nature of the drug problem is changing, and new approaches are needed.

The conference upon which this volume is based, held at the Heritage Foundation on March 20-21, 1990, was designed to take stock of America's war on drugs, highlight the approaches that are working, identify the areas in which progress is still needed and explore aggressive and innovative approaches to dealing with the parts of the problem that so far have defied solution.

Some background helps to place this conference in the proper perspective. In the 1950s and early 1960s, drug abuse was limited to a subculture of society. For the most part, the only time that subculture came in contact with society in general was when drug users committed crimes. Drugs were not, however, a significant part of mainstream America: They were not present in our schools or workplaces, on our roads or in our movies, music and television shows.

In the mid-1960s, with rise of a set of permissive attitudes personified by Timothy Leary, the rebellions on the campuses and the increase in drug use among young people, the drug situation changed significantly

and became part of the mainstream of American life, where it persisted in the 1960s and the 1970s.

In 1981, when Ronald Reagan became President, he asked Attorney General William French Smith to appoint a task force to find out what the federal government could do to assist local law enforcement in dealing with the problem of violent crime. That task force, which included led by Governor Jim Thompson and former Attorney General Griffin Bell, interviewed dozens of local police chiefs, sheriffs, district attorneys, heads of state law enforcement agencies and others. Almost to a person, these state and local officials said the federal government's top priority should be to do something about the drug problem, because drugs were one of the major causes of crime throughout the country. Partly as a result of those recommendations, Dr. Carlton Turner was asked to join the White House staff as the President's Drug Policy Advisor, assigned to develop a comprehensive strategy for the federal government to deal with the problem of drugs.

Dr. Turner's work resulted in the nation's first comprehensive drug strategy, which was released by the President in 1982. It laid out five areas of activity: International cooperation; strong law enforcement; prevention and education; treatment and rehabilitation; and, research. Updated strategies were prepared every two years from that point on. Then, in 1987 and 1988, detailed strategic plans for the federal agencies were developed by the National Drug Policy Board.

More recently, in September 1989 and again in January 1990, the Office of National Drug Control Policy, under the leadership of William Bennett, has issued updated strategic plans. Virtually all of these plans have addressed the same five major areas that were addressed in the original 1982 strategy. The content of those plans, however, has changed to accomodate the changing nature of the problem and our improving understanding of how to deal with it. We have learned, for example, that there are limits on our ability to keep drugs out of the country. We have learned that treatment programs for those already addicted to drugs are both more costly and less effective than we hoped. And, we have seen dramatic changes in the problem itself, with the explosion of cocaine and its deadly cousin, crack, the development of new "designer" drugs and, on the positive side, real successes in reducing drug use among the middle class and, especially, the young.

Most recently, the National Institute on Drug Abuse released data indicating that the number of regular drug users in America dropped

from 23 million people in 1985 to 14.5 million in 1988, a drop of some 37 percent. At the same time, the number of cocaine overdoses continued to rise, and the plague of drugs and drug-related crime in our inner cities grew, by all indications, much worse.

This volume is intended to provide insight into the changing nature of America's drug problem and new approaches for dealing with it. Part I of the volume consists of a single paper, by Dr. Carlton Turner, which examines carefully the overall trends in drug use touched on above, with an emphasis on what is happening today and is likely to happen in the immediate future. Parts II and III consist of short papers addressing two areas in which recent efforts have been successful: Casual drug use by adults and drug use by young people in our nation's schools. These papers highlight the most successful strategies that have been adopted in these areas, strategies that need to be continued and expanded if we are to continue to make progress.

Part IV contains a provocative set of papers addressing areas in which our efforts have not produced the desired results. These papers look at the growing problem of drugs and crime (James K. Stewart), the impact of drug use on the inner city health care system (Dr. Beny Primm), our inability to keep drugs out of public housing units (James Moran) and the connection between drugs and welfare (Dr. Robert DuPont).

Part V highlights the role that citizens can play in fighting drugs and drug-related crime. It focusses on three efforts, two here in Washington and one in Oklahoma City, Oklahoma, in which citizens' groups have taken aggressive steps to rid their communities of drugs.

Finally, Part VI presents some concluding remarks and recommendations from Office of National Drug Policy Director William J. Bennett.

There is no question that tremendous progress has been made in reducing drug use in the United States. Conservative policies, including a renewed emphasis on law enforcement, can take some credit for that progress. The real credit, however, rests with the American people, who saw where drug use was leading and rejected both drugs and the permissive attitudes with which drug use was associated.

Now Americans are asking their government to join them in taking the steps needed to drive drugs out of the areas where they continue to thrive. This volume is dedicated to them, and to the hope that

government will have the wisdom to do what is needed to win the final battle in the war on drugs.

PART I

THE STATUS OF DRUG USE IN AMERICA

Recent Trends in American Drug Use

The Honorable Carlton E. Turner

Recent reports about drug use in America present a confusing picture. On the one hand, we have strong indications that the total numbers of people using drugs is falling fairly rapidly. On the other, we see continuing evidence of high levels of drug use in some populations, and the crime and health consequences of drugs continue to mount at alarming proportions. My intention in this paper is to put these figures into context and to provide some insights into what is really happening, and is likely to happen, with respect to the drug problem in America.

The Modern History of Drugs in America

To understand where we are today, it is necessary to understand how we got here. When did the drug epidemic begin, and how did it originate?

Many people believe that the modern drug epidemic started with rock music in the 1960s, with the protests against the Vietnam war and with a professor at Harvard who went around the country talking about the mind-altering effects of drugs and how everyone should "turn on and tune out."

Regardless of the causes, though, by the end of the 1960s, it was clear that drug use was an important factor in society. In fact, by 1967, virtually every university in this country had experienced drug use on their campus. At the same time, it became clear that there were no federal, state, local or regional strategies to deal with the problem. There were some actions being taken, but they were *ad hoc* actions that were not tied together as part of a general strategy.

The prevailing attitudes at that time were that our problem was heroin, that it was an inner city and that, since most people did not live

in the inner city and did not experience problems with heroin, most people did not have a drug problem.

The federal government's efforts to do research and disseminate information about drugs were the responsibility of the National Institute of Mental Health (NIMH), and drug policy was not a very high priority. In fact, NIMH did not disseminate very much information about drugs because the people there felt there were not many research reports or projects under way that would stand the scrutiny of rigorous scientific evaluation.

In fact, the most significant event in drug policy during the 1960s had nothing to do with NIMH. It was the adoption in 1961 of a uniform convention on narcotics substances by the United Nations, signed by President Johnson in 1967, which said that no country could legalize any of the drugs covered by the convention (including opiates, cocaine, and marijuana) unless all of the signatory nations to the treaty agreed. That convention still forms the basis for many of America's drug laws, as well as those of other nations.

Because we failed to understand what was happening during the 1960s, we entered the 1970s believing that heroin was our number one drug problem. Most of our law enforcement resources were against that particular drug, and in response to the heroin problem we created the Drug Enforcement Administration and the National Institute on Drug Abuse.

But what was really happening at that time was that we were undergoing a significant change from a heroin problem to a broader problem with marijuana, cocaine, and other drugs.

No one had a "feeling" of what was happening in the country until 1972, when a first national survey of drug use was published. In this report, heroin literally did not show up in the statistics, but among 12- to 17-year olds, 0.6 percent were using cocaine, and 7 percent were using marijuana. Of the 18- to 25-year olds, 28 percent were using marijuana and 2.5 percent of those over 26 had used it. (Cocaine use was too rare to show up in either of these age groups.)

These numbers should have caused an uproar, but they did not. In fact, there was no strong sense of indignation among the public. To the contrary, the general feeling was one of user's rights, i.e. that everyone has a right to use drugs, and in general, a right to do to their own body what they wanted. To the extent drugs were seen as a problem, it was still viewed as an inner city problem and still associated with heroin.

Thus, we ended up thinking in terms of two categories of drug use. There was the serious problem of heroin in the inner city; and then there was the fact of drug use among the middle class youth.

Then, in 1976 and 1979, the next two years in which national surveys of drug use were published, a really significant increase in drug use, across the board, was seen. By 1976, one percent of the 12- to 17-year old population had used cocaine and 12.3 percent were using marijuana on a monthly basis. By 1979, 1.4 percent used cocaine and 16.7 were using marijuana. So, between 1972 and 1979, America experienced a tremendous escalation in drug use among young people.

The same thing happened in the 18- to 25-year old group, where by 1979, cocaine was used regularly by 9.3 percent and marijuana was being used by 35 percent of the population. For the over-26 age group, use increased to six percent for marijuana and 0.9 percent for cocaine.

By 1979, drug use in this country was a serious problem. One out of nine high school seniors was using drugs on a regular basis. They were using an average of 3.6 joints of marijuana a day, which meant they were stoned from the time they got up until the time they went bed. They couldn't learn.

There is some confusion about the precise demographics of drug use at that time, but it is clear that the problem was widespread and existed in each area of the country. It was not just an inner city problem anymore. It had spread to most high schools and it had spread to rural America.

The age group with the highest concentration of users was 15- to 25-year olds. That is important, because if you follow that group as it has aged, you will understand most of what has happened with drug use since then.

You can also look at that group and understand why we were beginning to see cocaine make significant inroads. Why? Our best predictor of who would use cocaine was someone who has used marijuana a hundred times or more. As marijuana peaked and broadly spread among young people in the late 1970s, cocaine use followed. This fact was something that very few policy people want to know or understand.

Despite these troubling signs, our nation did not respond with a national program. In fact, in 1978 and 1979, funding for the DEA was significantly reduced and our law enforcement efforts generally were cut back to save money. Bills were introduced into Congress to reduce

penalties for drug use. States had "decriminalized." In reality, as our law enforcement efforts and our indignation against drugs decrease, a significant increase in drug use occurred.

During this, a gentleman named Dr. Peter Bourne on the White House Staff, as the President's drug policy advisor was supporting the concept, "Don't worry about cocaine. Cocaine is so expensive only the wealthy will be able to afford it. They'll know how to use it recreationally and responsibly." And, the Director of the National Institute on Drug Abuse was actually advocating decriminalization of drugs.

The interesting thing was, if any other health problem in the United States had been creating these kinds of problems, it would have been addressed as an epidemic and steps would have been taken to stop it. But the drug issue was discussed in terms of individual rights, not in terms of health, and we acted, or failed to act, accordingly.

By 1980, the general attitude towards drugs was one in which everyone had rights, but no one had responsibilities. Some 27 percent of the junior enlisted men and women in the United States Armed Services were using drugs on a regular basis. The tenth national opinion survey of Who's Who Among American Students – these are top high school students in America – showed that 7.5 percent used marijuana on a monthly basis and that 11 percent said they would use it if it were legalized. Still, we heard the constant calls for decriminalization and the continued gutting of law enforcement efforts.

Beginning in the early '80s, things began to change. President Reagan changed the lay of the land. He changed the lay of the land in terms of how drug abuse was defined, so that drug abusers were not just heroin addicts, but anyone who used illegal drugs, including marijuana, cocaine, PCPs and other drugs previously classified as "soft drugs." He changed the lay of the land in terms of the balance between rights and responsibilities.

Looking back at the survey data from that period, we can now say with a great deal of assurance, that the total number of drug users in this country peaked between 1979 and 1982, at approximately 23 million people. Those same surveys tell us, as I mentioned earlier, that the drug problem was pretty much defined by the age group that graduated from high school around 1979. Overall drug use peaked among college students – people who had graduated from high school one to four years earlier in the early 1980s.

As surprising as it may be to some people, the total number of drug users in America peaked more than ten years ago, and has been on a steady path of decline ever since.

It is interesting to look behind these numbers at what was happening to underlying attitudes about drug use, especially among young people. In 1978, only 42 percent of teenagers opposed decriminalization of drugs. Ten years later, in 1988, that number was up to 77 percent. For all adults, the numbers were similar: 62 percent opposed drug legalization in 1978, compared with 89 percent in 1988. So the policies and attitudes of the Reagan Administration were clearly reflected in a hardening of attitudes towards drug use in the general public. The fact has been reflected in the national polls, as well as support for increased law enforcement efforts, and tougher penalties for drug users.

Where are we today? First of all, overall drug use has continued to fall, from 23 million regular users (about 12 percent of the population) in 1985 to 14.5 million regular users (7 percent of the population) in 1988. That is a significant change. Second, and I think this is important, young people in America have responded admirably to our efforts at reducing drug use. The high school seniors survey in 1979 found one in nine using drugs on a daily basis; in 1989 that number was one in thirty-three. For the military, which is also largely young people, the rate has fallen from 27 percent in 1980 to less than 5 percent today.

Unfortunately, our policies, and especially the focus on education in the schools, continue to be based on the presumption that the drug problem resides primarily in the high schools. I am all for educating young people against drug use. But I am concerned that we are paying too little attention to the group where drug use really resides today, the 20 to 40 age group that includes, not incidentally, that one key cohort I mentioned earlier – the high school seniors from 1979 and thereabouts.

If you look at the 20- to 40-year old population in the 1988 household survey, 12 percent said they use illegal drugs monthly and 22 percent said they use them at least once a year. For 12- to 17-year olds, the comparable figures were 9 percent for monthly use, and 17 percent for annual use.

Many people ask, "What can we do to reduce drug use in this 20 to 40 age group?" We can put them in jail! We have to get tough on them, and since most of them are either in the job force or just entering it,

that means dealing with drug use in the workplace. That's where workplace drug testing comes in.

We first learned about the effectiveness of workplace drug testing from our experience in the military. We learned that when you develop a procedure to detect the drug user and hold drug users accountable for their actions, changes occur. In fact, in the military, as I mentioned earlier, we saw drug use drop from 27 percent to under 5 percent, primarily as a result of implementing comprehensive random drug testing with treatment offered to those who wanted help and discharge for those who refused help.

Now drug testing is being introduced into the private workplace. One result is that we are, for the first time, beginning to get excellent reproducible scientific traceable data on the number of drug users, as opposed to only survey data of the past. Those data are also telling us that the survey data of the past were fairly accurate.

If, for a company first starting a drug testing program, it is very common to find 30 to 35 percent of job applicants testing positive on pre-employment tests. That may seem like a high figure, but remember, survey data tell us that the highest rates of drug use are in the 20-40 age group and people coming in to the workplace are usually in that category.

In ongoing drug testing programs, roughly 14 to 25 percent of employees test positive on any given day for any illegal drugs, and that figure matches very nicely with the survey data. It also, by the way, matches nicely the proportion of people who oppose legal sanctions against the drugs.

As the use of drug testing in the workplace becomes more widespread, we can expect to see these numbers decline. But we're going to continue to see negative consequences of on-the-job drug use for many years. To get an idea how serious that is, just look at the transportation area. Between January of 1987 and November of 1988, there were 60 major rail accidents, including the Conrail/AMTRAK accident in Maryland, where one or more of the employees involved tested positive for an illegal drug. Those accidents resulted in 33 deaths and 360 injuries.

Apart from drug use in the workplace, what else can we say about the approximate 7 percent of our population that still uses drugs? We know that use is higher among males than females, and higher in large metro areas than in suburban or rural areas. On a regional basis, we

find that the West Coast has the highest rate of use, at about 10 percent. Some 18 percent of unemployed workers use drugs regularly, and 9 percent of part-time workers. The only group experiencing a significant increase in drug use is Hispanics, who went from 7 percent in 1985 to 11 percent in 1988. Usage among whites and blacks was stable or went down.

It is surprising to most people to learn that cocaine use went down along with the use of other drugs. The 1985 survey found 5.8 million regular users of cocaine; in 1988 that was down to 2.9 million, a 50 percent reduction. That is a significant drop, but one that will not be reflected in the newspaper headlines for some time to come. Why? Because I am talking about the number of users, not the adverse health consequences or crime reports in newspapers. Unfortunately, those are still going up.

The reason we are still seeing increases in health and crime problems is that once one starts using cocaine, there is a period of time before they need the help from health care providers or they become involved in reportable crimes associated with drugs. You just do not use cocaine one day and wind up in treatment or in jail the next.

What we are now seeing with drug related crime is, in fact, a result of a shift that started several years ago. The 1980s saw a reduction in intravenous (IV) drug use because of its relationship to the AIDS epidemic. As people reduced IV drug use, whether heroin, cocaine, or methamphetamines, they switched to smoking cocaine and PCP instead. Smoked cocaine, in particular, became so popular that it began to replace other drugs, even including marijuana. As that trend progressed, a significant increase in drug-related crime occurred.

Why? One major factor is the difference is the effects on the human body of different drugs. Drugs such as heroin and others that suppress the central nervous system may lead people to commit crimes, but these crimes are not usually committed under the influence of the drug, but rather in an effort to secure more drugs. Cocaine users, on the other hand, are more likely to commit crimes when they are under the influence of the drug. Thus, when the shift from marijuana to smoked cocaine occurs, a corresponding increase in violent crime was recorded.

Similarly, if you look at the number of emergency room admissions for cocaine, you find that as people started smoking cocaine, the number of people coming into the emergency room for smokable

cocaine (crack) increased significantly. There were only 549 emergency room admissions for cocaine in 1984. In 1988 there were 15, 306. Once again, we are seeing a significant decrease in the total number of users, but correspondingly significant increases in the health consequences and the law enforcement impact of those particular drugs.

What do these trends tell us about the future? First, drug arrests are probably going to continue to rise, because the number of arrests is really a measure of our law enforcement effectiveness, and if there's any one group in our society that has been effective in fighting drugs, it has been the law enforcement community.

Yes, there will be more pressure to create drug treatment centers, and that means higher costs for private businesses, as well as the government.

As law enforcement continues to be more effective, we are going to see another interesting phenomenon: a loud outcry by the users for decriminalization and legalization. That happened during the 1970s when drug users were arrested and it is beginning to happen now. They will point to the fact that arrests are going up, prison time is going up, and health care costs are going up, and they will say those costs are too high. Thus, the only solution is to legalize or "decrim." However, I do not think the "decriminalization" movement will be as successful this time as it was in the 1970s: too many people are opposed.

"Can you win?" The answer is yes we can, and we are. This is, in my opinion, America's third drug epidemic. The first one occurred after the Civil War. The second one, which was our first cocaine epidemic, was at the turn and early part of the century, and at its peak, it encompassed about 30 percent of health professionals, such as pharmacists and physicians. Even the father of modern surgery in the United States of America was addicted to cocaine.

We conquered those epidemics, not with permissive attitudes, but by strong resolve and by putting the pressure on and saying that everyone has to accept responsibility for their actions. That is how we will ultimately conquer our current epidemic of drug use.

PART II

SUCCESSFUL STRATEGIES FOR COMBATTING CASUAL DRUG USE

"Sting" Punishments for Drug Users

Ronald Susswein

Speaking as a prosecutor, one of the problems I have with the language we use in talking about drugs is the false distinction we sometimes make between the "supply side" and the "demand side" of the problem. We tend to think of these as discrete problems, and then we go further and say that law enforcement's job is to curtail the supply of drugs, whereas education and treatment are responsible for demand reduction.

I believe that law enforcement also has a role to play on the demand reduction side of the equation, and I want to discuss one way that law enforcement can play such a role.

In general, law enforcement has, and must have, some responsibility for helping to change people's attitudes about the drug problem. In New Jersey, we have a model of how to do that, which has also been used throughout the country, and that is the drunk driving model. That problem has not been solved, by any means, but the model has shown that tough laws coupled with zealous enforcement can get people to at least think twice about that very limited part of the substance abuse problem, drinking and driving. The proof of that is not only that highway fatalities have gone down, but we have new words in our vocabulary – designated driver, for example. When new words find their way into the common vernacular, you know that you are having an impact – in this case, by increasing the chance of getting caught drinking and driving.

The drunk driving model shows how law enforcement can serve as a deterrent or, in today's terms, a prevention strategy. They really amount to same thing: the threat of something unpleasant happening prevents you from doing something you should not do. For example, we know from our 1987 survey of New Jersey high school students that 70 percent said that the fear of getting into trouble with the law will prevent their use of an illicit drug.

We have a responsibility in law enforcement to try to take advantage of that preventive factor, and the key lies in the phrase "user accountability." We know that the casual user is morally responsible for much of the carnage and much of the tragedy of the current drug epidemic, and we have to find a way to transform their moral culpability into legal accountability. Further, we have to do that through realistic punishment. We cannot afford to have laws, such as the very well-intended but poorly conceived Rockefeller law in New York during late 1960s and early 1970s, which are simply too tough to enforce.

What we need is a rational policy that achieves a delicate balance—laws tough enough to be worth enforcing but not so tough that we cannot afford to enforce them. That means, in particular, that we need alternatives to prison as a means of punishing drug users.

As a prosecutor, let me say quite candidly that I love tough penal laws. I like penal laws that you need a calculator to figure out the criminal's penal exposure in terms of the number of years he is going to serve. But that is not the answer in this case, and in New Jersey we have recognized that.

What we have done is develop what we call "sting" punishments that meet what I think are the two most important criteria for a rational punishment. They are cheap and they are hurtful. They get people's attention and they do not cost a whole lot to impose.

One such punishment is cash penalties. We have a mandatory cash penalty for drug users in New Jersey drug enforcement, which we call Drug Enforcement Demand Reduction Penalty (DEDR). If you are convicted of any drug offense in New Jersey, you will pay a minimum penalty of $500, and up to $3,000, which is fixed and which the judge has absolutely no discretion to waive. If you cannot pay that penalty immediately, we allow you to pay it on a payment schedule.

One benefit of DEDR is that it provides a stable funding base for some of our drug programs outside the law enforcement area. And, while the people that we arrest are hardly triple-A credit risks, we have collected in New Jersey more than $11 million through this program. For us in New Jersey, that is a significant amount of money.

The other punishment we have developed involves the driver's license. Any person convicted of any drug offense in New Jersey automatically loses his driver's license for six months, and the judge can increase that two years. And, since in New Jersey we do not have limited drivers licenses, this means the complete loss of all your driving

privileges, with no exceptions to allow you to get to work or whatever. That is tough punishment. And we tell people who argue, for example, that they will lose their jobs, that if your job was that important to you, you should have thought about that before you used drugs.

Further, we take away driver's licenses whether or not an automobile was involved in the offense. The rationale here is not, as it is in the case of drunk driving, to get the dangerous driver off the road. Here, the dominant theory is punishment. This is something that hurts and gets people's attention.

If you are too young to have a driver's license at the time of your offence, which means 16 or younger in New Jersey, the six months minimum loss of driving privileges takes effect when you turn 17, and becomes a postponement in when you can first get your license.

Does this penalty work? When I visit high schools to talk about drugs, the kids tend to sit there glassy-eyed until I mention the driver's license law. Then, all of a sudden, the hands shoot up. There's a gasp: "That's unconstitutional." And then we get into a good debate of why it is not unconstitutional. In fact, the law has been upheld quite easily in our courts, and that provides a good civics lesson.

What we are trying to do with this law is to provide one additional reason, an excuse, if you will, for young people to say no. It is not necessarily the most important argument in our arsenal, which includes providing a mandatory, K through 12, drug awareness curriculum. But it is law enforcement's small contribution. And we can hear kids saying, "I'm not going to risk my license for that crime." And that's important, even if those individuals were not going to say yes anyway.

A recent national Gallup Poll indicated that 57 percent of teenagers thought that the taking of a driver's license would be a "very effective" deterrent. In New Jersey we surveyed our students and asked them specifically about the New Jersey law. The first thing we found out was that 84 percent of our high school students knew about the driver's license law, and that number goes up dramatically as students approach age 17.

Furthermore, 40 percent of our students indicated that the presence of this law "strongly influenced" their decision whether to use drugs. Only 25 percent said that that law would make no difference.

Now, I will acknowledge to the cynics that in certain populations the driver's license is not that important a sanction. On the streets of Newark, for example, the threat of the loss of driver's license is not that

important, because many of the young people there do not get their driver's licenses when they turn 17.

Nevertheless, among key populations, this is a very effective punishment.

We do everything we can to make people aware of the law and to enforce it as openly as possible. For example, the law requires the court to physically take possession of the driver's license at the time of sentencing, and that takes place in open court.

People are also getting the message that we are enforcing this law simply based on the number of times it has been used. In 1988, the first year the law was in effect, we did revoked 9,600 driver's licenses. Through the the first eight months of 1989, we took an additional 13,150.

Those kinds of numbers, by the way, show how important is the role for state and local governments, because you could never expect the federal courts to handle that kind of case flow. It takes the state courts and the local courts, especially the municipal courts that run 30 cases a night, to enforce a program like this one. These are the places where those licenses are biting the dust in New Jersey, and that is why we are starting to have an impact.

How effective are these "sting" punishments. In suburbia, among high school populations, we know from survey data that the driver's license is having a tremendous effect. The cash penalty is having a tremendous effect as well. And, the program continues to have the support of most people in New Jersey, including the state legislature. We think it has been successful, and we intend to keep implementing it and building on it.

Mandatory Drug Treatment for Drug Users

Thomas Agnos

Maricopa County, Arizona, where I serve as Sheriff, is not exactly a sleepy little place. Phoenix is the county seat. We have about two and a half million people in the county. Geographically, the county is larger than about seven states and about the same size as thirteen other states. We're located about 60 miles from the Mexican border, and less than 300 miles from Los Angeles, so we get quite a bit of traffic coming through the Phoenix metropolitan area.

We have implemented a program in Maricopa County aimed at the so-called casual user. First, let me put the importance of the casual user into perspective, in the following way: the Jack Daniels Corporation and the Seagram's Corporation do not manufacture whiskey to satisfy the needs of alcoholics, and neither do the producers of illicit drugs manufacture drugs to satisfy the needs of addicts. They both produce to satisfy the casual or social user. It is estimated that 70 to 80 percent of the drug abuse in the United States is by the so-called casual user. So that is our target.

When we first approached this issue several years ago, I was with the Phoenix Police Department. We realized that, like most other law enforcement agencies for the past quarter century, we had been going after street dealers and traffickers, and the problem was not going away. In fact, it kept escalating.

We began to wonder at that point whether we were attacking the right part of the problem. We were after the supply side of the problem, and we were having no success whatsoever. So we decided to take a look at the user, because the user is somebody that we can have some influence on.

We realized that the drug problem in the United States is not in Peru or Bolivia or Colombia or Mexico. It is right out here on the streets of our cities and towns, in our schools and in our workplaces. For a quarter of a century we had looked at the user as somewhat of a victim

of the drug problem. But the user is not a victim. The user is every bit as guilty of all of the evil that is being perpetrated by illicit drug use as the trafficker is. The user is where the problem is, and that is where we decided to put our resources.

The environment we work in, in terms of the state laws, is a good one. Arizona has mandatory sentencing laws regarding illicit drugs. All drug offenses are felonies in Arizona, with the exception of an ounce or less of marijuana, which is a Class 6 felony which the court has discretion to make a misdemeanor. The minimum fine is $650 for marijuana plus a 40 percent surcharge (the maximum fine can be up to three times the value of the drugs plus a 40 percent surcharge), which takes the total fine up to about $1,000 for possession of the smallest amount of marijuana. Those are tough penalties, and they provide a good backdrop for what we have done in the Phoenix area.

The user accountability program we have developed in Maricopa County is known as "Do Drugs, Do Time," and it has three components: enforcement, education and opportunities for rehabilitation.

The enforcement component is made up of 21 law enforcement agencies in the Phoenix metropolitan area, plus three federal agencies, the FBI, DEA and the U.S. Attorney. We have all banded together to share our resources in going after the casual drug user. This program does not deal with alcohol offenses. It does not deal with juveniles. We have programs to address these areas, but they are separate from "Do Drugs, Do Time."

We have a task force that is made up, in total, of about 55 police officers. The county is divided into three areas, and one part of the task force is responsible for each area. Each group gets information from the various towns in its areas, and when it learns that there is a particular drug problem in a given location, it will move into that area and work it for two to three days. On occasion, we will put the entire task force together and have it work an area, so that you get 55 people working in one particular area.

Our target is the casual drug user, the person who lights up in a bar or is in the parking lot snorting a line of cocaine. We look for those people, and then we make an arrest. There is zero tolerance on who is arrested. Everybody goes to jail, no matter what amount of drugs is in their possession, and they stay in jail anywhere from an hour to a couple of days.

Once people are in jail, there are some options that we make available to them. For those with no previous felony convictions, or no drug convictions in the last year, they may be eligible to go into a diversion program. This is where another component of the program, opportunities for rehabilitation, comes into the picture.

People eligible for diversion are offered a drug rehabilitation option by the County Attorney. However, there is a cost associated with it. First, each person who is arrested must pay me, the sheriff, $50 for every day they are in jail. Then, they must pay their way through the rehabilitation program, the cost which equates approximately as to what the fine would be if they were convicted of whatever drug possession they were arrested for. For those arrested for marijuana, the cost is about $1,000. If the arrest is for cocaine or a harder drug, the cost is about $3,000, which is normally what the fine would be. I should also point out that we have a sliding scale of fees for participating in the diversion program, depending on income, and for truly indigent there is no cost for the program.

For those who choose the rehabilitation option, the program lasts up to a year, with frequent urinalysis testing, seminars that they must attend and other kinds of assistance. If they pass through the program successfully, the charges are dropped totally, and they go about their business.

For those who opt not to take the program, they are vigorously prosecuted by the County Attorney. Similarly, if they fail out of the rehabilitation program, they will be vigorously prosecuted by the County Attorney.

In the year this program has been in effect, we have made about 5,000 arrests. Slightly more than 50 percent of those arrested have been eligible for the diversion program. About 35 percent of that 50 percent have taken the diversion option – 17.5 percent of all arrestees. Another 18 percent are still pending a decision. Only about 10 percent have refused the diversion option, and they are being prosecuted as vigorously as possible.

We have put back about $400,000 into the county general fund from fees that have been collected from individuals who have opted into the diversion program.

With respect to the education component of our program, we spend a lot of time in the schools, including going into the primary grades. We have about 85 percent of the schools in Maricopa County covered by

a police officer through our DARE program. We have also met with about 750 business people to begin getting them to put on education programs within their businesses.

What are the results of all these efforts. First, we know that public awareness is up substantially. A recent poll taken in Maricopa County indicated that 85 percent of the people there were aware of the "Do Drugs, Do Time" program. They have either seen the public service announcements we have run in conjunction with it or have heard about it in some other fashion.

We have also seen a reduction in the percentage of people we arrest who test positive for drugs. We book about 100,000 people into the Maricopa County Jail every year, and our pre-trial services office does voluntary drug testing on individuals who come into the system. In 1988, slightly more than 50 percent of all the individuals booked into the Maricopa County Jail had some form of illicit drug in their system. By the end of 1989, the year that this program took effect, we have seen a 5 percent decrease, down to just a little over 45 percent now coming into the system have some kind of illicit drug in their bodies.

I do not have scientific evidence that this reduction is the result of our program, but I do think we are having some impact on the attitude towards drugs in Maricopa county. And that, really, is what we are trying to do. Five thousand arrests is, in our metropolitan area, not a whole lot of arrests. But I liken this program to our efforts with respect to smokers or people using seat belts: not very many people went to jail for not using their seat belt or smoking in an elevator, but yet we have had a great deal of success in changing peoples attitudes so that those things are less likely to happen. That is essentially what the "Do Drugs, Do Time" program is designed to do – to begin changing the attitudes of our people so that they do not get involved in the drug culture to begin with.

What else needs to be done? The next step is an in-custody rehabilitation program in the county jail system, so that courts have a way of sentencing an individual to some kind of in-custody treatment within the county jail system. We want to be able to put in place a mandatory in-custody treatment facility within the Maricopa County Jail that will address 50 percent of our arrestees who are not eligible for the diversion program.

In addition, we are looking at revoking some of the licenses that are governed by the state, such as attorneys', doctors' and beauticians'

licenses. We would like to see our legislature take a strong stand that says if you are a convicted drug abuser, you are not going to be an attorney or a doctor or a beautician in the state of Arizona if you have a history of drug use.

We are also looking at increasing the use of asset forfeiture, and in particular at seizing criminals' property, everything except a home, to pay their way through the criminal justice system. I think this has a good deal of merit, especially when you think about how we treat our elderly in the United States. We literally drive our elderly to poverty in nursing homes before government will step in and take care of them. With criminals, it is just the opposite. We will take care of criminals, even including giving them heart transplants if they need them, all at no cost. Yet, we let them maintain a car, a boat, a camper, a summer cabin, jewelry and all their other assets, and do nothing about making them pay their way through the system.

The long and short of it all is that we have seen user accountability have an impact on the drug problem in Maricopa County, and we are going to continue implementing our current programs and expanding them as long as we see them continuing to work.

Successful Treatment Programs for Cocaine and Crack

Mark S. Gold, M.D.

Although cocaine abuse in this country has reached epidemic proportions, the 1988 National Household Survey on Drug Abuse found some cause for hope. Data from that survey showed that the number of current cocaine users – people who had used the drug within the past 30 days – had decreased by 50 percent from 5.8 million to 1985 to 2.9 million in 1988. The number of people who had used cocaine within the year fell from 12 million to 8 million in the same period. In January 1988 over 40,000 people called the National Helpline 800-COCAINE seeking help and information about drugs; in June 1990 this number dropped to 18,162. To a significant degree, the decline can be attributed to widespread public education about the dangers of cocaine.

The bad news is that the number of people using cocaine every day or every week rose during the same period. In addition, among the nearly 3 million current users are half a million people who use crack, the highly addictive smokable form of cocaine and the most dangerous development in the long history of this deadly drug.

History of Cocaine

While the history of cocaine has been thoroughly discussed elsewhere (1-3), for a physician the relevant issues of its history largely concern the changes over time in dosage, route of administration, patterns of use, and the technology of cocaine production.

The Incas of Peru were among the earliest recorded users of cocaine. The amount of cocaine ingested by the Incas was probably low; even though it is estimated that the average user chewed 60 grams of coca leaves a day. Given that the alkaloid content of a cocaine leaf is about

0.5 to 0.7 percent and that only a portion of the alkaloid is absorbed in digestion, the total dosage would have been only 200 to 300 mg a day (4).

Perhaps the next significant period in the history of cocaine began in 1884 when Sigmund Freud published his essay "Uber Coca" (5). In this paper Freud advocated the therapeutic use of cocaine as a stimulant, an aphrodisiac, a local anesthetic, and as a medicine for treating asthma, wasting diseases, digestive disorders, nervous exhaustion, hysteria, syphilis – even altitude sickness (6). Freud, who himself used cocaine in dosages of about 200 mg a day, recommended cocaine in oral doses of 50-100 mg as a stimulant and as a euphoriant in depressive states (7, 8). For 90 years his essay was the only report that used controlled studies to document the effects of cocaine on humans (9).

Freud also prescribed cocaine to alleviate the symptoms of withdrawal from alcohol and morphine addiction. Because the addictive power of cocaine was not then recognized, some patients who used cocaine as a substitute for alcohol or morphine became addicted to cocaine instead. As these and other adverse consequences of cocaine use soon became apparent, Albrecht Ehrlenmeyer accused Freud of having unleashed "the third scourge of humanity," the other two being alcohol and opiates.

In America, during the mid-1880s, Atlanta druggist John Pemberton devised a patent medicine that contained two naturally occurring stimulants: cocaine and caffeine (10). Because it contained no alcohol, he advertised his product – eventually known as Coca-Cola – as an "intellectual beverage," a "temperance drink," and a "brain tonic" (10-12). Until 1903, Coca-Cola contained approximately 60 mg of cocaine per 8-ounce serving. The maker voluntarily removed cocaine from the formulation in response to public pressure and to news reports about the dangers of cocaine.

The turn of the century thus also marked a turn in public attitudes about cocaine. The American Medical Association, seeking to raise the standards of medical practice, lobbied to curb the sales of patent medicines, including those containing cocaine. The Harrison Narcotic Act of 1914, which mistakenly listed cocaine as a narcotic, banned the use of cocaine in proprietary medications and tightened the restrictions on the manufacture and distribution of coca products (1).

Stimulant abusers searching for a "safe" recreational high soon rediscovered cocaine (13). In the early 1970s, cocaine abuse skyrocketed, especially among middle- and upper-middle-class populations, where it became known as "the Champagne of pharmaceuticals." The warnings of cocaine's dangers from the previous cocaine epidemic during the late 19th century had long since been forgotten.

During the 1970s cocaine was usually administered intranasally. A typical user bought a gram of cocaine for approximately $150 and snorted the drug from a tiny "coke spoon" or perhaps even a fingernail cultivated for the purpose. Such methods delivered between 5 and 10 mg of the drug. A "line" of cocaine inhaled through a straw delivered approximately 25 mg. Typical users would repeat the dose in both nostrils, thus taking between 10 and 50 mg of cocaine at a time (14).

The perception among users at the time was that cocaine was safe and nonaddicting. The medical literature of the time did little to contradict this false perception. As the supply of cocaine arose, the price dropped and the amount of a typical dose increased. A new method of cocaine administration called "freebasing" allowed users to smoke the drug and ingest much higher doses than ever before (3). Some users combined cocaine and heroin in a drug cocktail known as a "speedball" – the combination that killed comedian John Belushi.

The arrival of the crack form of cocaine in the mid-1980s opened another tragic chapter in the history of the drug. Essentially mass-produced freebase cocaine, crack is low-priced (as little as $3 a dose), making it available to younger users and sending the average age of the user spiraling downward. Causing users to feel more confident, more intelligent, more in control, and sexier, smoked cocaine is rapidly addicting and produces medical effects previously seen only in long-term intranasal users (15). By 1987, 56 percent of callers to the 800-COCAINE hotline reported that they were smoking their cocaine; just four years earlier, only 21 percent said they were freebasing (16).

Cocaine Use Today

Surveys of callers to the 800-COCAINE National Helpline conducted from 1983 to 1989 have identified some shifts in the current cocaine epidemic. For example, in 1983 the typical caller was a 31-year old intranasal cocaine user, college educated, and employed with an

income over $25,000. By 1989, the typical caller was less educated, unemployed, a non-intranasal user, and had an income under $25,000.

Another way of measuring the impact of cocaine use is by looking at the data on emergency room visits. Between 1976 and 1986 there was a fifteen-fold increase in the number of emergency room visits due to cocaine and in the number of admissions to public treatment programs for cocaine (17). Cocaine-related ER visits jumped again by 86 percent in 1987, largely because of the swelling use of crack (18). Nearly one in four drug-related ER visits involves some combination of drugs and alcohol (19). A 1988 survey by the Drug Alert Warning Network (DAWN) found that one out of four cocaine-related emergency room visits was related to crack smoking, compared to one out of twenty in the previous survey (20). By 1989, cocaine was the number one cause of emergency room visits in Washington, D.C. and New York City as well as Atlanta, Baltimore, Chicago, Indianapolis, Detroit, Los Angeles, New Orleans, and many other cities across the nation (21).

Autopsies revealed the presence of cocaine in over 18 percent of motor vehicle fatalities in New York City between 1984 and 1987 (22). It is highly likely that the well-known direct effects of cocaine – feelings of alertness, euphoria, aggressiveness, irritability, psychotic distortions, increased risk-taking behavior – diminish a driver's ability to control the vehicle (17, 34). Similarly, more than 70 percent of those arrested in such major cities as New York, Philadelphia, and Washington tested positive for one or more drugs, usually including cocaine (24). Recent cocaine use is associated with a range of violent premature deaths, including homicides, suicides, and accidents (25).

The likelihood that a person will become addicted to cocaine depends to a large degree on the method that person uses to ingest the cocaine. One study conducted by the Outpatient Recovery Centers (ORC) of Fair Oaks Hospital found that cocaine smokers were twice as likely to fail to complete their treatment program compared to intranasal abusers. Other elements that determine addiction liability are: the psychological and physical changes brought about by drug use, the degree of that change, the speed of onset of the change, the duration of change, and the postdrug effects (27).

Cocaine tends to be less addictive when ingested orally in small doses. If the dose is small the onset of the effects of the cocaine is slow, the duration of action is long, and the unpleasant withdrawal effects are absent or very mild.

Given the characteristics that define the probability of addiction, cocaine is most addictive when it is smoked. Cocaine can be smoked as coca paste, as freebase, or as crack. The popularity of crack compared to freebase is largely a product of marketing techniques which make small amounts of high-quality cocaine available at low prices and without having to undertake a dangerous chemical process to convert cocaine to a smokable form.

In actuality, smoking is not an efficient method of delivering cocaine to the body. A significant portion of the drug dose is lost when the cocaine is heated in preparation to be smoked. The effects of the drug come on very quickly; only 8 to 10 seconds pass before the user experiences the high. The concentration of the drug in the brain also occurs more rapidly when smoked, resulting in greater behavioral effects.

Also contributing the addiction potential of crack is the fact that the effects of the drug last only 5 to 10 minutes. After the high is over, the crack user feels anxious, depressed, and paranoid. Such a rapid shift between positive and negative effects of the drug make users crave another "hit" of the drug to restore the euphoria they felt just moments before (28).

The Effect of Cocaine Use on the Central Nervous System, the Mind, and Behavior

Cocaine's addictive potential is in part the result of its effects on the neurochemistry of the brain. Recent laboratory research has established that cocaine acts directly on the so-called reward pathways. These pathways are indirectly activated by pleasurable stimuli from other activities, including eating, drinking, and sex. So powerful is the direct stimulation provided by cocaine that sleep, safety, money, morality, loved ones, responsibility, even survival become largely irrelevant to the cocaine user. In a sense, cocaine "short circuits" the process by which people normally achieve gratification and security (29).

The precise effects of cocaine use depend on many factors: the purity of the drug, route of administration, frequency of use, the personality and mental health of the user, past and present use of drugs

and alcohol, the environment in which the drug is used, and other drugs taken at the same time (30).

Whether a user enjoys or likes cocaine may depend on the individual's normal level of excitation. Because cocaine stimulates the central nervous system, a person with a low level of excitement may be more likely to tolerate the changes in alertness that cocaine provides. On the other hand, people who are normally hyperexcited may feel uncomfortable and may experience a feeling of unhappiness after cocaine use.

Cocaine users report feeling more alert and higher in energy. This reaction in turn produces a tremendous increase in self-confidence, self-image, and egocentricity. Some groups of people, including athletes, salespeople, entertainers, musicians, even physicians sometimes use cocaine to provide them with these effects, to enhance their energy, confidence, and "star image" (26). Despite the feeling of arousal many individuals experience while using cocaine, they do not get any particular superior ability or greater knowledge. Their sense of omnipotence is only illusional; they tend to misinterpret their enhanced confidence and lowered inhibitions as signs of enhanced physical or mental sharpness (31).

There are limits to the degree that the central nervous system activity can be artificially stimulated (26). The tremendous desire to repeat the pleasurable aspects of the cocaine experience and to counteract the depressive effects of post-cocaine crash can lead to compulsive chronic use of the drug (17). After chronic use, or following a prolonged binge, symptoms of depression, lack of motivation, sleeplessness, paranoia, irritability, and outright acute toxic psychosis may develop (26). Terror of impending death can occur in persons with no preexisting psychopathological conditions (17, 32, 33).

A further complication of cocaine abuse is that many users improve some of the unpleasant stimulating effects of cocaine by accompanying their cocaine use with sedating agents, such as alcohol or marijuana (17, 28).

Treatment of Cocaine Addiction

The evaluation and initial treatment of cocaine-using patients is a complex, demanding, and sometimes confusing process (34) that begins with the initial diagnosis of the patient. However, the correct

diagnosis of a cocaine abusing patient is made more difficult by several factors, such as: the tendency of most addicts to deny their drug use; failure by many medical professionals to routinely consider drug abuse as a potential cause of a patient's symptoms; hesitation by employers and medical professionals to use urinalysis as a means of detection.

Once drug abuse has been identified, thorough treatment requires the physician to integrate a range of medical, psychiatric, social, and drug counseling services. Adding to the complexity is the need to address family issues and to anticipate the risk of relapse. Although currently the success rate of treatment for drug addiction is less than would be desired, new treatment strategies, including some pharmacologic interventions, offer hope for improving the outcome.

In recent years many treatment facilities have adopted the chemical dependency model, which regards drug dependence as primary condition – a disease unto itself – not a secondary problem arising from some other underlying psychopathology (35). Such programs take a multidisciplinary approach to drug treatment and provide a range of behavioral, cognitive, educational, and self-control techniques aimed at reducing drug cravings and the potential for relapse. Significantly, these programs also require patients to abstain from all drugs and to participate actively in Twelve Step programs such as Alcoholics Anonymous or Cocaine Anonymous. The advantage in doing so is that patients learn to consider themselves as being continually at risk and in a recovering – rather than a recovered – state. They also learn to see themselves as chemically dependent, not crazy. Such a fundamental shift in perspective improves the chances that the patient will live a happy, healthy and drug-free life.

Inpatient vs. Outpatient Care

If circumstances permit, outpatient treatment is the preferred method for delivery of care for several reasons. The majority of cocaine abusers can be treated as outpatients, since use of the drug can usually be stopped abruptly without medical risk or significant discomfort. The goal of treatment is to return the patient to a normal life; by definition there can be no "normal" life inside the hospital. The cost of outpatient treatment is lower (although some insurance companies may refuse to pay for care delivered in the outpatient setting). Many patients are more willing to accept help on an outpatient basis since it carries less

of a social stigma and is less disruptive to daily life. Given the rising demand for treatment, there may be more outpatient treatment slots available. Perhaps the most important consideration, however, is that in all cases of substance abuse, outpatient care will eventually be needed, given the lifelong risk of relapse and the need for ongoing support (37).

One advantage to hospitalization is that a stay in a treatment facility removes patients from the environment -- the home, the streets -- that may be contributing to their drug use. Patients under round-the-clock supervision are unable (in most cases) to obtain illicit drugs. They can take daily advantage of the many types of therapy (individual, group, creative and so on) the hospital offers. Another advantage is that patients are available for full medical and psychiatric evaluations, which will reveal whether any co-existing problems, such as clinical depression, exist that require additional treatment (38). Many of these problems only emerge, and can only be properly evaluated, after detoxification and during observation over a period of several drug-free days.

Treatment Strategies

Planning treatment requires a comprehensive assessment of the mental, social, and pharmacological aspects of the patient's substance abuse. For many patients, cocaine use is the focus of their entire life. They become totally preoccupied with drug-seeking and drug-taking behaviors. They may have become accustomed to the mood changes invoked by cocaine and have forgotten what life without drugs is like. Thus they come to regard the drugged state as "normal" and may not believe any treatment is necessary. For this reason they may refuse to acknowledge the need for help. Many patients thus enter treatment only under pressure from family, friends, employers, or the judicial system (33). In severe cases, the patient perceives such pressure to be a threat from "enemies," which only serves to reinforce drug-induced feelings of suspicion, persecution, and paranoia. For this and other reasons, families often need guidance in staging an intervention on a cocaine-abusing relative.

Medical Treatment of Withdrawal and Cocaine-Related Emergencies

As a rule, symptoms of cocaine withdrawal are not medically dangerous (39). Detoxification from cocaine requires no treatment other than abstinence (34). However, many patients find the symptoms of withdrawal intensely unpleasant, so much so that they feel driven to continue acquiring and using cocaine in order to fend off the symptoms. Any medical treatment that helps relieve withdrawal symptoms therefore improves the prognosis enormously.

Recent studies have demonstrated that the antiparkinsonian medication bromocriptine (Parlodel), which acts by stimulating the dopamine receptors of the brain, may be highly effective in reducing initial cocaine cravings. With their cravings under control, patients are more likely to avoid relapse and to benefit from other forms of therapy.

Long-term Treatment of Cocaine Dependency

Patients with dependency problems usually experience the best outcome if treated by physicians, psychologists, and other caregivers who specialize in managing addictive disorders (36). In recent years increasing demand for treatment has led to the burgeoning availability of specialized treatment centers in many parts of the country.

Whether it serves as the primary mode of care or as a sequel to hospitalization, a comprehensive outpatient program should include a range of treatment strategies. These include supportive counseling, drug education, peer-support groups, and family meetings.

In all cases, patients should be given frequent urine tests to screen for all drugs of abuse. The goal must be to achieve abstinence from mood-altering chemicals, including alcohol. Attaining this goal can not be determined simply by asking the patient, family or loved ones if he or she "is still using drugs." We should ask this question and look for drugs in the urine. There is no hope for effective treatment so long as the patient continues to use drugs. Personality problems, emotional difficulties, and psychiatric disorders need to be addressed as they arise, but the chances of success are virtually nil unless the patient is drug-free.

Another crucial element of long-term treatment is participation in a Twelve Step recovery program. In recent years the medical and psychiatric professions have come to recognize the significant con-

tributions AA and similar programs can make to the lives of substance abusers. Members draw strength and security from meeting with others who understand and share their concerns and can offer practical strategies for surviving "one day at a time." Any treatment program that does not embrace the Twelve Step approach and encourage patients to participate stands little chance of long-term success.

Preventing Relapse

Despite progress in treatment for cocaine use, the risk of relapse is extremely high. As noted, the memory of cocaine euphoria is so powerful that it can produce overwhelming urges to revert to drug use. Patients whose lifestyles revolved around cocaine are susceptible to being reminded of the drug in surprising ways. For example, a patient who see talcum powder, bread crumbs, or snow may be reminded of cocaine. Seeing cocaine-using friends or locations can trigger drug urges. The click of a cigarette lighter or the light from a match is enough to remind some patients of their cocaine-smoking habit. Apparently, almost any stimulus that has been repeatedly associated with obtaining and using cocaine can become a cocaine "reminder"(40).

The most promising approach to treatment of cocaine abuse is one that recognized the high risk of relapse and applies a range of cognitive and behavioral strategies, including a Twelve Step program, to minimize the risk.

Outcome of Treatment

The chance of relapse among cocaine patients is high; most treatment specialists acknowledge that they offer treatment, not a cure, for addiction. There is reason for hope, however. Perhaps a decade ago, only 10 to 20 percent of drug addicts recovered following treatment. More recently a study found that, on average, up to 80 percent of substance abusers treated for three months or longer had reduced their drug use significantly, and that fully 50 percent were still completely drug-free a year after treatment ended (41). Some hospitals today report a success rate of 60 to 70 percent. Results of a survey conducted among 101 consecutive patients by Fair Oaks Hospital in Summit, New Jersey, revealed that six months following discharge, 85 percent of cocaine addicts were drug-free (42).

The best treatment strategy, however, is to prevent drug use before it starts. Educating people about the dangers of cocaine has already had a tremendous impact. Physicians can play a significant role in reducing the cocaine epidemic by inoculating their patients, especially the younger ones, with large doses of the facts about this dangerous and deadly drug.

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PART III

STOPPING DRUG USE IN THE SCHOOLS

Holding Students Accountable for Drug Use

John Murphy

Anyone who saw the President's televised speech on drugs remembers him talking about Dooney Waters, the young man who had been so devastated by drug use in his home. Dooney is a student in the Prince George's County schools, where I serve as Superintendent. So, let me put this issue of the impact of drugs in the schools into some perspective by recalling Dooney's story and by providing some other data on what we are seeing in Prince George's County.

Dooney was called to my attention by his teachers and his principal. And this is what actually happened: Dooney was in the second grade at the time, and at the end of the day he walked up to his teacher, tugged at her skirt, and said, "Can I go home with you at the end of the day today?" And the teacher said, "No, Dooney, I can't take you home. That's against all the rules. I have no permission from your family to take you back to my house."

Dooney said, "Well, if I can't go home with you, can I stay here in the school all night?" And the teacher said, "No, Dooney, I can't let you do that because it is going to be a very dark, cold and scary place after we turn out all the lights this afternoon."

But Dooney responded, "Well, I'd rather stay here than go home because when I go home, the Jamaican gangs have taken over our apartment complex and they make us go out and work in the streets. The first time when they held the gun to my head and pulled the trigger and I just heard the click, I wet my pants," Dooney said, "but now I'm brave; I don't wet my pants anymore."

When we see children coming into our public schools from these kinds of conditions, we are talking about a public school environment that is vastly different from anything that we have ever had to deal with in the past in American public education. We are talking about children who are totally traumatized by the violence associated with drugs in their communities.

We have one school in our district where, in the immediate neighborhood, there were sixteen murders committed. Children come to that school having witnessed the violence associated with the use of drugs in their community on a daily basis. We face the challenge of developing an educational climate that helps us to compensate for those kinds of problems, a climate that gives these youngsters the kind of foundation they are going to need to be successful in life, so that they do not go back into the cycle and repeat what is happening in their communities right now.

We are all aware of the problem of cocaine-addicted babies.

Some estimates suggest there were as many as 350,000 cocaine babies born in America last year. There were 1,000 born just in Prince George's County. What impact are these babies going to have as they move through the school system?

Roughly 8 percent of the students in Prince George's County are served under the Public Law 94-142, the Education of the Handicapped Act, at a cost of about $60 million. We spend as much as $100,000 per child with some of our special education services to help these children. And nearly all of that is local money, because federal funding has never followed the program, even though it was promised.

That is a problem for us already, but what is going to happen when those 1,000 cocaine babies start coming through our doors? And if we have 1,000 a year over the next several years, what is going to happen to the cost of special education and the other services that we will be required to provide to those youngsters? Recently, I travelled to Los Angeles to visit the only experimental program in the nation, dealing with cocaine babies in public schools. Los Angeles has had a pilot program in operation now for three years. The ratio of teachers to children in that program is two teachers per five children, supported by psychologists, doctors and social workers. That gives some indication of the kind of cost that we will be talking about when these cocaine-addicted babies begin to enter the public schools.

Those costs cannot be avoided, and we need to do everything we can to help those children. But we also need to do everything we can to make certain that we do not continue down this path for another decade.

That is the environment we are working in, and it explains why we have taken such an aggressive stance against drugs in the Prince George's County schools. What exactly are we doing?

First, we have an intensive K through 12 curriculum where we provide drug education and try to alert our youngsters to the problems associated with drug use.

Second, we have a very strong school policy that requires students to pay a real price for using drugs or distributing drugs in our schools.

Third, we have developed student support service programs, peer assistance programs, and after school activity centers, all in conjunction with the surrounding communities, which I think are extremely important.

Our drug education curriculum begins in kindergarten and will eventually go all the way through grade 12. At present, because of the costs, we are not offering programs at every level in middle school or high school, but we are in grades K through 6. By 1991, every student will be exposed to a drug education curriculum every year.

In addition to this formal curriculum, our students have developed a series of very exciting programs called the "Lookout Series." This program was developed by the students at our K-8 grade performing arts school, and involves a series of skits in which the students are the actors. These skits are designed to provide information and teach specific skills on how to remain drug free. They involve role playing activities, "interviews" with drug experts and "visits" to drug resource centers. These programs involve students and their families as active participants in the program. We also participate actively in Project DARE.

Are these education programs having any effect? The University of Maryland recently completed a survey on drug use in our school district, and it found overwhelming evidence that these programs have alerted youngsters to the dangers of drug use. And, as a result, we have seen some immediate reduction in overall drug use.

We also have a very firm disciplinary policy towards drugs. With respect to drug possession, our policy is that any youngster caught with drugs will be expelled, unless the child and the child's parents agree to immediately enter into a drug counseling program. If they do enter into a drug counseling program, and complete that program successfully, we allow them to remain in school. The drug counselling option is one we added last year. Until last year, our policy stated that anyone who was caught with drugs in Prince George's schools was immediately expelled, period. As we examined that policy, however, we decided that

we had an obligation to do something more than send these youngsters out onto the streets, in effect passing them along to some other agency.

Since the new policy took effect in the latter part of 1988, we have had 64 first-time violators referred for disciplinary action involving drugs. Of those, 63 youngsters have taken advantage of the counseling program and are still in school working toward solving their drug problems. If anyone is caught with drugs in their possession for a second time, they are automatically suspended from school. Any student caught selling drugs on school grounds is automatically expelled.

There is a good deal of evidence that these tough policies have been very effective. In September through June of 1985-86, we expelled or suspended 283 students because of drug possession, drug use, or drug sales. That dropped to 191 in the 1986-87 school year, and to 131 for the 1987-88 school year. Through March of the current (1989-90) school year, we have had only fifteen cases of suspension or expulsion for drug possession or sales. It is clear to us that our policy, which says to students that there is going to be a stiff price to pay if you are caught with drugs, is having an impact on reducing the number of youngsters who are using drugs, at least on school property.

The third area in which we have been active is in developing student support programs and working with other resource groups in the community. For example, we have participated actively in the Operation PROM Program to help students stay alcohol and drug-free on prom night, and the Red Ribbon campaigns, in which students participate in week-long "I'm drug free" activities, National Drunk and Drug Driving Awareness programs, the American Heart Association "Save a Sweetheart" Program and the American Cancer Society's antismoking programs. Kaiser Permanente has been working with us to provide literature for our students. Our Chamber of Commerce has been developing human resource partnership programs. The Washington Bullets have been working effectively with youngsters in our schools to make them aware of the evils of the drug culture.

In our highest impact neighborhoods, where our youngsters are getting the greatest exposure to the drug sellers in the streets, we are also creating after-school centers. These programs, which are provided at no cost to parents, allow children to stay in school until 6 p.m., when most parents get home from work. During those after-school hours, we conduct a great deal of drug counseling, as well as academic counseling. We believe this program is going to be extremely successful in

helping to combat the kind of temptations those youngsters would normally receive if they were going home to those neighborhoods at 2:30 in the afternoon.

In summary, what we have done is put in place a comprehensive program that addresses some of the most pressing problems associated with drugs. Our tools are education, backed up with tough discipline, backed up further with a whole variety of programs aimed at getting students involved in positive activities and out of drug activities. The results to date indicate that we are having a significant impact on reducing drug use in the Prince George's County Schools.

Testing Students for Drug Use

John Schwaller

I hold the title of Student Assistance Coordinator at Homewood-Flossmoor High School in Flossmoor, Illinois. There is a message in that title, and a specific reason that I do not carry the title Substance Abuse Coordinator: We want our students to understand that our drug policy, which includes drug testing for most of our students, is designed to assist students, not to punish them.

In my role as Student Assistance Coordinator, I am responsible for education, prevention, intervention, aftercare and support of students who may have chemical problems in the high school, and in eight grammar schools that feed into the high school. I also provide assistance to family members that may have chemical problems.

The student population in these nine schools is about 5,600. Obviously, I cannot do all of the things that I am supposed to do by myself, so I empower a lot of the people, and we have a lot of volunteers and parents and community agencies which work with us.

There are a number of elements of our anti-drug program, but the one which obviously gets the most attention is our requirement for drug testing for interscholastic athletes, and that will be my focus here.

Let me begin by telling you how that program got started. Homewood-Flossmoor High School is typical of most suburban high schools in America. We are primarily a school serving a professional community, middle-class, with some students who are lower income. Like most high schools, we have had problems with our students falling prey to drugs, we have implemented programs to deal with that problem, and those programs have had some success, but not enough.

In July 1989, one of our football coaches approached me and indicated that he knew of students on his team who were using drugs, that he had confronted both the students and their parents, and that both the students and the parents denied there was a problem. "Maybe

if I had some proof," he said, "we could change these kids' lives around before they get worse."

That conversation started the ball rolling for us to develop random drug testing in our high school. That September, our school board approved our current policy on random drug testing, which covers all students participating in extracurricular athletics. It may seem surprising that the policy sailed through that quickly, but in fact we have had very little resistance to it from the very beginning. We surveyed our students about the policy before implementing it, and 70 percent said they were willing to take the tests and that they believed that it was worth it to help those with drug problems. Our parent organization has also backed the policy up with the administration.

I should point out that we looked at some alternatives to random testing, including voluntary testing for students who wanted to be tested. We concluded that there would not be too many students who were using drugs who would voluntarily submit to testing.

We made the decision to limit our coverage to athletes because of court precedents which indicated that programs limited to athletes would pass constitutional muster. Athletes have communal undress, they are required to have physical examinations, they are subject to training rules involving some aspects of their lifestyles, and so forth. Courts have found that because of these factors, athletes have a diminished expectation of privacy, and therefore random drug testing is appropriate.

We also found that limiting testing to student athletes still gave us significant coverage of our student population. We have 2,100 students in the high school. Out of that population, 1,100 are student athletes. Of those, about 250 participate in more than one sport. So fully two-thirds of our students are covered by random drug testing.

We also looked at expanding our program to include cheerleaders, as some of other schools have done, and we may do that at some point. We chose not to at this point because of the possibility that it would result in lawsuits. The ACLU discussed bringing a court action if we tested other than student athletes. So right now we are just going with what is safe from a legal perspective.

Our policy calls for random testing of student athletes during the season for whatever sport they are participating in. We test 5 percent of the students participating in any given sport in any given season. We conduct the tests on a weekly basis, and we do not announce in advance

what day of the week the tests will be done. The only two people that know the schedule are the person from the lab that does our testing and the athletic director.

Our testing is done on-site at the high school, in a separate facility next to the football field, because we found that was the place where we could most easily guarantee privacy. When our students go to get tested, they list all the chemicals, such as over-the-counter drugs and prescription drugs, that they might have taken during the previous 30 days that could cause the test to be positive. Then they go into a room and provide their sample, under the supervision of a technician the entire time. Then the samples are picked up by a courier and taken to Smith-Kline Laboratories, which does our lab work.

If the test results are negative, then a letter is sent out within a five-day period to the parents to let them know their child's test was negative.

If the test comes out positive, on the other hand, the first thing we do is a second, confirmatory test. We also consult with the physician who oversaw the testing to make sure that the child was not taking any prescription or over-the-counter drugs that might have caused the positive results. Also, if the student or parents want to challenge the results of the test, they can do two things. First, they can pay to have the sample re-tested. Second, they can ask for a hearing before the Athletic Director and the Student Assistance Coordinator.

If the positive result is confirmed, the child has 48 hours to go in for an assessment with a drug counsellor at a hospital or private facility. Part of my job is to refer children to the appropriate counselling facility, and in most cases we are able to do something at no cost. The counsellor will talk with the student and with the parents, and will also get some information from us about how we think the student can be helped. The result is the development of a plan for how we help this individual. That plan can involve paid treatment or, if the parent is not in a position to pay, we can refer the student to one of a number of government-funded facilities in our area where treatment is available at no cost.

As long as the student follows the recommendations of the counsellor, they may continue participating in athletic activities, after a 30-day suspension. They will be re-tested, and we will monitor their participation in the treatment program to make sure they are following through. All of these procedures are described fully in a manual that we have made available to all students and parents. We felt it was important that

we understood all the possibilities and ramifications before we started in the program, and made parents and students aware of exactly what would happen under different circumstances.

Our ultimate goal is to help the students, not punish them. If a student tests positive, but then follows through with the treatment, then they can go on just as before, with no long-run consequences. We do, however, have long-run follow-through assistance available, through in-house Alcoholics Anonymous and Narcotics Anonymous meetings in our school, during school hours. We also have an aftercare support group for students who are coming back from treatment, because we have found that it is very hard for students coming out of treatment and they need that kind of support.

What if a student who tests positive refuses to go for an assessment? First, they are automatically suspended from extracurricular sports for two weeks. After those two weeks, if they still have had not taken the assessment, they are out for an additional four weeks. If they still have not taken the assessment after those four weeks, they are out for a calendar year.

We test for the ten most common drugs, including alcohol, marijuana and cocaine. The cost of the initial screening is $38 per student. If that test comes out positive, then we do the confirmatory test using the gas chromatography/mass spectrometry method, which is an additional cost of about $500. The cost of the entire program is estimated at between $40,000 and $50,000 per year. We have been fortunate to have a private-sector donation that is covering $25,000 of that, and a hospital that has given us $10,000 to cover counselling and testing. Finally, we take $1 per ticket from our sales at sports events and put that towards drug testing. Thus, at this point, the program is being financed without any tax dollars.

We are in the third month of our program, and it is too early to have any results in terms of reduced drug use or other broad indicators. Let me emphasize, however, that the purpose of drug testing, as we see it, is as a deterrent. It is just one tool in our prevention program. It is not the end all and be all of prevention, and it may not be right for every high school. We concluded that this was an area where we could try to do something different, and see if it works. We will be analyzing all the results as time goes on to see if it produces the kinds of results we hope for.

The "DARE" Program

Rick Nash

As a law enforcement officer, I have been personally involved with Maryland's Drug Abuse Resistance Education (DARE) program for three years. I began by implementing the program in Carroll County, Maryland, three years ago, after being introduced to it by current partner, Jim Allender, who is with the Baltimore County Police Department. Currently, Jim and I serve as statewide coordinators, working to implement the DARE program on a statewide basis.

The DARE progam was developed in 1983, by Los Angeles Police Chief Darrell Gates. Chief Gates recognized the need for the police to work in cooperation with the Los Angeles Unified School District, and they launched a drug prevention education program that employed uniformed law enforcement officers working in elementary or middle schools and they work as regular instructors.

He worked with Drs. Ruth Rich and Joanna Goldberg, both with the Los Angeles Unified School District, to develop a curriculum, and the program got underway during the 1983-84 school year.

In that first year, ten officers went into the Los Angeles schools and taught the program to some 8,000 students. Since then, the program has grown to a point where it is now in 49 states and five foreign countries. It is also being used by the Defense Department for children in the school military school system.

The overall objective, of course, is to prevent substance abuse among adolescents. DARE targets the children at the age when they are most vulnerable, before they are likely to have been exposed to the peer pressure or experimented with tobacco, alcohol and drugs. The goal of the program is to prevent drug use by equipping elementary and junior high school students with skills for recognizing and resisting the social pressures to experiment with drugs and alcohol.

The unique feature of this program is its use of uniformed law enforcement officers. These officers are selected on the basis of having firsthand knowledge of drug abuse and its victims, and that is clearly one of the keys to its success. While a teacher could teach the program,

only a law enforcement officer who has been out in the trenches can relate the personal experiences that go along with that.

Equally important to DARE's success, however, is the training that DARE officers receive. Before entering the classroom, they receive training not only in drug abuse education but also in classroom management, learning modalities, child development, narcotics recognition and other related topics. Altogether, each DARE officer receives a minimum of 80 hours of intensive training.

The curriculum itself is excellent. The lessons focus on providing accurate drug information, teaching resistance techniques, improving self-esteem, providing positive alternatives, understanding media influences and building support systems. We avoid the kinds of scare tactics which some people may remember from the 1960s and 1970s, focussing instead on assessment and resistance techniques. The program also includes a question box, which lets children ask questions they might not be able to ask in the open classroom.

Another key to the program's success is that DARE officers work closely with the children they are teaching. They not only teach a structured seventeen-lesson curriculum, which usually amounts to four or five 45-minute classes per day, but they also work with the students and get to know them. They take lunch with students, go to recess, attend physical education classes and so forth. And, there is a parental involvement component that encourages interaction between the parents and children, so that we actually build a partnership between the parents and the school and the police.

The strong rapport with students that DARE officers have been able to build has led to benefits that, frankly, we never expected. I think every officer that has taught the program has had experiences in which they have been able to help individual students. For example, I have personally been able to identify and get help for children who have been sexually abused and who have problems with drug abusing parents. One girl called me at home to tell me that she was offered drugs on the school bus. When I went to her house to discuss it, and she decided,

based on what she had learned about drugs in her DARE class, that she wanted to report it, and we put a stop to that. Things like this are happening all the time.

In summary, the program really does work. The impact has already been significant. There have been several long-term studies,1 and what they have found is a decrease in school vandalism, a decrease in truancy, improved ethnic relations, reduction in gang activity and a more positive attitude toward the police.

This success is leading us to expand the DARE program in Maryland as rapidly as possible. Approximately 90 percent of the school systems in the state have expressed an interest in having the DARE program, and we are are currently working to train 80 new DARE officers so that we can have DARE in 90 percent of the schools in Maryland in September.

1 Project DARE Evaluation, National Institute of Justice, 1985 (Los Angeles Police Department and Los Angeles Unified School District). DARE in Kentucky Schools (Social Research Laboratory, West Kentucky University, 1989).

PART IV

HARD CORE DRUG USE AND ITS CONSEQUENCES

The Connection Between Drug Use and Urban Crime

The Honorable James K. Stewart

The topic I have been asked to address is "The Connection Between Drug Use and Urban Crime." In addition, I've been asked to discuss the apparently conflicting data and trends that have been reported on drug use by so-called hard-core users and by casual users.

This second half of my assignment won't take long. But it is going to take us along the edges of areas assigned to other speakers and panelists. I hope they will forgive me this trespass.

Finally, I'd like to suggest some ways in which we can begin doing something with – and for – the people whose drug use makes the rest of society fear them the most. Those are the people involved in urban crime, of course.

Let me quickly sketch out some background. One reason we have the drug problem that we do today is that our society defined the problem incorrectly in the '60s and '70s. There was a lot of ambivalence back then.

Was drug use indeed a crime? Or was it merely love children expressing their free spirit, at the dawning of the Age of Aquarius?

For many people, it was just friends dealing with friends, sharing a couple of joints together. For some, it was seen primarily as a health problem. Even among the people who viewed it as a crime, many saw it as one without victims.

The professionals told us that drug use among criminals was no more extensive than among the rest of us.

In 1974, Dr. Peter Bourne, who later became President Carter's drug policy advisor, called cocaine "the most benign of illicit drugs currently in widespread use." He questioned why the Drug Enforcement Administration was trying to interdict cocaine shipments.

Sixteen years later, we have evidence all around that cocaine use is not benign. It has long-term and lasting consequences, particularly in the areas of criminal conduct.

The crack epidemic. International cartels. Pervasive street markets. The destruction of lives of family members, as well as those of the individuals directly involved. All these ills have been spawned because we misunderstood the drug problem.

Part of it was that we lacked good data, not only about drug use and its effects, but about the linkage between drug use and crime. As with many social issues, the kind of data we can get determines how we define the problem. And how we define the problem, typically, determines how we go about trying to solve it.

The first real data on drug use came in 1972, when the National Institute on Drug Abuse started its Household Survey, from which it was able to extrapolate weekly drug use in the population, aged 12 and older.

In 1979, NIDA's annual High School Senior Survey began giving us data. About 16,000 high school students fill out its drug use questionnaires every two or three years.

Both the Household and High School Senior surveys, however tend to exclude many of the people most likely to be part of the criminal element. These are high school dropouts, or prisoners, or people living temporarily in institutions or on the street. More importantly, these surveys tell us about drug *use*, not drug *consequences*.

One of our objectives at the National Institute of Justice is to identify relationships between drugs and crime. Our conclusion is that drugs – even if they were legalized – have serious implications for public safety. Drugs don't cause crime in the sense that users immediately run about creating havoc. They accelerate existing criminal tendencies.

One NIJ study showed that criminals are four to six times more active when they're on drugs than when they're not. A study of California prison inmates showed that those who were addicted to heroin when on the street committed fifteen times as many robberies, twenty times as many burglaries, and ten times as many street thefts as non-users. A study of crack-using teenagers in Miami showed that they averaged 205 street thefts and 37 major felonies per year. Two other studies showed extremely high drug use among arrestees in Washington, D.C. and New York City.

Some social scientists will remain unconvinced, arguing that correlation doesn't prove causation. In other words, the frequent appearance of drugs and crimes together can't tell us which came first. This is true statistically but it shouldn't get in the way of common sense. I almost

always find frogs and ponds together, for instance, but I have no trouble figuring out which came first.

Moreover, not all studies have been strictly correlational. Studies of the California Civil Addict Program (CAP), for, example, found that participants increased their criminal activity when addicted and decreased their criminal activity when they decreased their drug use. That, ladies and gentlemen, is causation – not of crime but of the acceleration of criminal tendencies.

A major tool in advancing our knowledge about the drug scene is urine testing.

We had funded some earlier research in Washington. It suggested that trends in urine tests of arrestees had predicted the heroin epidemic in the city in the late '70s. They did so a year to a year-and-a-half sooner than other community indicators of drug use.

Unfortunately, no one had known to check the urine tests for that purpose.

The policy question was obvious: If we could do broader urine testing of arrestees, would the results give us a leading indicator of drug usage nationally, or at least city by city?

We decided to find out. That was the beginning of DUF, or the Drug Use Forecasting program, which NIJ began implementing in 1987.

DUF involves obtaining anonymous and voluntary interviews and urine specimens from a sample of the people arrested in 22 large cities. These arrestee samples and interviews are obtained at each city's central booking facility on a quarterly basis.

We want to make sure that a range of offenses are represented. Therefore, people arrested for drug offenses are intentionally undersampled. This means that DUF estimates of drug use represent the minimum you could expect to find in the total arrestee population, which includes many more people charged with drug offenses.

Do you know what we found out from DUF? We found out drug use among arrestees is much higher than the professionals – the police, the medical people, the corrections people – had believed. That's important, because much of our policy, our education, our enforcement has been based on what these professional experts believed.

We also found out that the experts underestimated by more than half – 23 percent versus an actual 56 percent – the people arrested who had used drugs 24 to 36 hours prior to their arrest. That was early on. In the most recent DUF data, 56 percent was the lowest for any city.

The highest figure by city was 84 percent for men... and 88 percent for women. Drug use among offenders is ten times greater than use among Household Survey respondents.

DUF also provided insights into the most commonly used drugs in each city. We had thought there was a national drug problem. We found out -- at least among the criminal element -- that it varies from city to city, from region to region.

It varies dramatically. The prevalent drug in New York City was and is cocaine. The drug of choice in Washington, D.C. is not – contrary to what you might think – "power," the drug that feeds the ego. Initially, the drug found most frequently through urinalysis in Washington was PCP; more recently, it has been cocaine. Cocaine use in the Washington area dropped nearly 12 percentage points in the last four months of 1989, but it's dropped nowhere else. Perhaps the Rayful Edmond conviction is having an effect on cocaine use in the nation's capital.

DUF shows us other variations in drug use. On the West Coast, amphetamines have been showing up in as many as a third – or even more – of arrestees. In other cities, amphetamines show up barely, or not at all.

Another thing the DUF research has shown is that you can't find out who's using drugs just by asking them. In the DUF cities, we find two to three times more drug use by the urine tests than we do by the arrestees' self-reports in the *anonymous* interviews.

The differences might be even greater if the urine tests could measure the prior 30 days instead of the previous two to three days.

If self-reporting by arrestees is suspect, what about self-reporting by household members and high school seniors? Dr. Eric Wish, a Visiting Fellow at NIJ, has just completed an analysis. He suggests there are easily more than twice as many frequent users of cocaine in this country as show up in the self-reporting of NIDA's Household Survey or the High School Senior Survey. That is, more than half of the frequent cocaine users in the country are contained in the criminal population.

That the most recent data from the Household and Senior surveys show cocaine use declining in this country has been widely reported. If we apply what we've found out about self-reporting in the DUF research, this decline may not be as great as it appears. What we may be seeing is casual users becoming less and less willing to admit their cocaine use. If that is indeed the case, we need to continue attacking drug use by the casual user. It's appropriate. It's working. It's curbing

drug use, even if at a lower rate than the data suggest. We need to keep it working with casual users, even as we try to reduce drug use among criminal offenders.

Clearly, we do need to try to cut drug use among the criminal element. Remember what NIJ's pre-DUF research found – that drug users commit four to six times more crimes when they're using drugs, than when they're not. But how might we cut this drug use among criminals? Let me offer some suggestions.

A few minutes ago, I said that we – our society – had made a mistake in how we defined the drug problem back in the '60s and '70s. Even those who saw drug use as crime saw it as a victimless one.

We made a second mistake back then in setting our goals – in deciding how to deal with the problem. If enough drug users simply go for treatment, we decided, that would take care of it. Given the shortage of jail space, the criminal justice system settled for putting convicted drug users on probation and referring them to treatment.

There was some follow-up to see if they went into treatment. But little effort went into seeing if they stayed in treatment, if they were staying clean, if treatment was having any effect.

Part of the problem was a lack of good tools. The early urine tests weren't all that sensitive, and were expensive. There was heavy reliance on detecting use through clinical signs, and self-reports. DUF has shown us how inaccurate self-reporting is – even anonymous self-reporting – by clients of the criminal justice system.

So the treatment agencies couldn't identify very well whether people were continuing to use drugs. Even when they could, moreover, they often bent over backwards not to act on infractions.

The criminal justice system, as a result, had no way of knowing if referring drug users to treatment was having the desired effects.

There also was a widespread view then that drug testing was heresy. In 1977, Robert DuPont, then Director of NIDA, wrote a paper on the trip-wire concept. He said that we know a lot about heroin; we know it's causing crime. Therefore, he said, we should set up urine testing for probationers and parolees, with a positive test acting as a trip-wire. When they tripped on that wire, we could know that we needed to do more with them.

DuPont was denounced, and worse, for what he said.

The testing at that time, of course, wasn't as sophisticated and quick as it is now. And now the problem is cocaine. Testing now costs $12 or

less a test, it takes about a minute, and it's highly reliable. Today, we're almost routinely using drug testing with people who are employed, or who are seeking employment.

Just as employers are insisting on drug-free employees, society has the authority to insist that anyone who's under supervision by the criminal justice system be drug-free. That means anyone who has been convicted of a crime, who is on probation or parole, or who has been arrested and is asking to be released on bail.

There's going to be a debate at the end of this program tomorrow about treatment versus criminal justice as a solution. I'm not going to take part, but I don't think it's "either-or."

I think we make a mistake by saying either treatment or criminal justice. Criminal justice alone can't handle it; treatment alone can't handle it. But when fused together, they are complementary; some experts call it "enforced" or "coercive" treatment.

Despite the experiences of the '70s, we now know we also can use a combination of testing and the criminal justice system as a tool to keep criminals off drugs.

This doesn't mean that we won't continue to need really stiff penalties for some offenders or that we don't need to expand – and be willing to use – our prison capacity.

But research is now emerging that shows that penalties don't have to be draconian for all offenders – for many, they just need to be of a level that forces the offender to "get the message." Research shows that having a swift and certain penalty is normally more important than its severity.

Let me tell you how it would work, with pretrial release (as is done in Washington, D.C.), as well as with post-trial sentencing.

The judge gives the arrestee or defendant a choice: "You can either go to jail, or I will put you on probation if you promise not to use drugs and to come in for testing once a week."

They don't necessarily have to go into a formal treatment program. Research shows that even habitual drug users frequently and routinely withdraw from drugs for periods of some time, without medical assistance. Several projects currently underway are trying to identify which drug-involved offenders will benefit from testing alone and which may also need drug treatment.

But the only way you can assure the drug user's cooperation is by testing. If you don't test, they'll lie to you, they'll cajole you, they'll do

anything they can to continue to use drugs. The point is to make them more accountable for their actions.

If it turns out they are still using drugs, the judge can tighten the screws, order them in for testing four times a week. Many users get the message right away. If they keep using drugs, the judge can order them to sit for eight hours in the holding tank. More get the message then.

And it they still continue to use drugs, it's into jail for contempt of court – which doesn't require a trial – for three to five days. That's the maximum penalty they get. But they can keep going back in for three to five days.

The judge could also order them into a treatment program. Research tells us that people who are ordered into treatment and threatened with jail time if they don't cooperate stay in treatment longer than people who go into the program voluntarily.

The treatment program costs money, of course. But while they're in the program, they're not out committing crimes. In one study, the re-arrest rate dropped to the same level as that of the arrestees who originally tested negative, who weren't using drugs. So there's a gain.

Let me illustrate the potential of this type of program numerically.

Suppose we start out with one hundred drug users who are ordered to stay drug-free. Fifty-five quit using drugs. Thirty continue to use drugs, off and on. Fifteen drop out, or fall out. They don't show up for testing, or they test positive every time, or they go out and commit another crime.

So of one hundred people in the criminal justice system, you've gotten fifty-five off drugs. You've got another thirty that you're working on. And you've got fifteen that the system needs to work on and for whom the sanctions need to be increased – and that may mean they will have to go to jail or prison.

I can draw a parallel with the issue of smoking. We've had educational efforts, warning labels, advertising bans, smoking bans on airplanes, defined smoking sections. But some smokers didn't change their habits on airplanes until there were a few arrests. That did it: A law had been enforced enough times to be symbolically compelling. And now virtually all commercial flights less than five hours in length are required to be smoke-free.

As public policy on drugs, this is sensitive enough to discriminate between the people who are most dangerous and least dangerous. By

doing that, we don't break either the system or the taxpayer. But we reinforce the value that drugs are bad.

Because we could make these people feel at risk without extended incarceration in most cases, the system would no longer be forced to bluff. What's happening now is that they're all calling our bluff – the attorneys, everybody. They're saying, "You can't put me in jail, because in order to put me in, you've got to put a bank robber, a rapist, a molester, a killer, back on the street."

♦ ♦ ♦

Private security in this country has grown into a 52-billion-dollar-a-year industry. Rather than each of us spending to protect ourselves and our property, it might be a better investment to assure that every drug user who comes to the attention of the criminal justice system has to become drug-free.

How about using money and other assets confiscated as part of drug seizures to purchase more drug-testing equipment? That would be one of the greatest ironies.

None of this is going to be easy. The adult offender – the hardened drug-using criminal – is really hard to treat. But that leads to my last point. That is the matter of juvenile testing and the important window it gives us.

One thing we've learned from DUF is that most adult drug users started their use in their early teens. DUF also is testing juvenile arrestees in four or five cities, and the District of Columbia has been testing all juvenile arrestees for two or three years.

We are seeing that the older the juveniles tested in the DUF program get, the more into drugs they get. By the time they're 16 or 17 years old, they look like the adult offenders that we test.

Although there's a lot of talk about kids in grammar school using drugs, we don't see that in the DUF information. We see people under 14 to be essentially drug-free. But as they move through the ages of 15 and 16, drug use really takes off. By the time they're 17, it's up to about 60 percent. What we find first is marijuana, and later we start to find cocaine and sometimes heroin.

But there's a window at about age 14. By applying lots of resources there, at that critical point, we may be able to keep these young people from jumping into drugs.

Most of our anti-drug programs today are in the sixth grade, at about age 10 or 11. So what we need is a reinoculation – a booster shot – to be sure these juvenile arrestees who have had the education about drugs get it reinforced at these danger years, at about the ninth grade.

Then perhaps our population of adult drug offenders will begin to decline.

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In the meantime, the criminal justice system offers a tremendous opportunity to do something. The people our society fears the most, the people who are the most dysfunctional drug abusers, the people who are out there committing crimes... they're coming through the doors of the criminal justice system every day.

It has them under its control, by law. It offers a tremendous opportunity to do something – to intervene in their lives and stop them. It can be an agent for getting them to change their behavior.

Why do we let them go?

Let's use drug testing to make sure they're complying with the terms of their probation or their pretrial release, to remain drug free. And if needed, let's use the criminal justice system to get them into treatment, and to keep them there.

Drug Abuse and Inner City Health Care

Dr. Beny Primm

Drug abuse and its effects are imposing a large and increasing burden on our inner city health care system and, indeed, on the health care system everywhere in this country. That burden is associated in part with the immediate and direct effects of drug use, such as overdoses, but related even more strongly to other health consequences of drugs, including mental illness, increased susceptibility to a number of diseases and, of course, transmission of AIDS. To understand the total impact of drug use on our health care system, you need to look at all these factors taken together.

It is impossible to understand what drugs are doing to our health care system without looking at the phenomenon of crack cocaine. What is crack? It is a smokable form of cocaine which gets to the brain very quickly, in about seven seconds. The high is very intense and extremely rapid in onset, and only lasts three to five minutes. The crash is intense, producing a feeling that is very distasteful, and that leads to the need for what are called "parachute" drugs to ease the pain when users come down. That parachute drug is generally alcohol or one of the other sedative hypnotics, and people who are addicted to crack are generally found to be addicted to these other kinds of substances that they use as parachute drugs.

The cravings crack produces are also intense. The addiction is extremely rapid. Crack is now the drug of choice among drug users in several major cities of the United States, particularly in Miami, Washington, D.C., New York City, Philadelphia, Atlanta, and New Orleans.

There has been a sharp increase in the use of crack among women, and the reason is that crack is smoked, and that is less invasive than taking other kinds of drugs. For example, people who use heroin generally inject that drug intravenously (going directly into the vein with a needle) or subcutaneously (just under the skin). Women general-

ly are more averse to needles, and thus find it easier to take cocaine and crack cocaine because you can snort it or smoke it.

This increasing use of crack by women includes, unfortunately, its use by women in their childbearing years. In New York City, which is where I have done much of my own work in treating drug abuse and its consequences, reported illicit drug use during pregnancy increased steadily through the 1980s. By 1988, nearly 35 out of every 1,000 live births reported in New York City showed evidence that the child had been exposed to drugs prior to birth.

The impact of that one statistic on our obstetrical and gynecological wards, where these babies are being delivered, is dramatic. We are seeing increasing numbers of "boarder babies," who are never taken from the hospital. And many of these babies are now being taken from their mothers, because it is considered child abuse to have abused drugs while the baby is in utero.

Crack use also leads to sex for money and multiple sex partners, many of whom have a history of intravenous drug abuse. This is important because people who have a history of intravenous drug abuse are infected with other kinds of diseases. The sharing of syringes, which are often used over and over, even without being cleansed, causes diseases to be passed from one addict to another.

AIDS is, of course, one such disease, but it is not the only one. Anything that you would think would be present in a shooting gallery in New York City, including such common diseases as streptococcus and staphylococcus, is being passed along with that needle, and all of these diseases contribute to the health problems experienced by addicts.

For example, we often see addicts who have terrible sores on their arms, which is what happens when they use up all their veins and begin injecting all of these organisms under the skin. In addition, heroin is usually cut with quinine, which kills the tissue immediately under the skin. Over time, the immune system can be devastated. In addition, addicts are at risk of developing subacute bacterial endocarditis, an infection on the lining of the heart. These individuals also frequently have major problems of the kidney, hepatitis, pneumonias and, of course, the severe dermatitis.

In 1987, I did a study of 1,897 patients I was treating in the treatment program I ran in New York City. Of these, 20.3 percent were anemic, 16.3 percent suffered from alcoholism, 15.5 percent had subacute

tuberculosis infection, 13.5 percent had hypertension or cardiovascular disease, 12.7 of them had psychiatric disturbances, 3.6 percent had kidney disease and 3.2 percent had tuberculosis. We also found high rates of epileptic seizures, diabetes and endocarditis. And, crack use and its related behaviors are also considered the major factor for the sharp rise in the number of cases of syphilis in crack infested cities such as New York, Miami and Los Angeles.

The spread of syphilis also has an effect on newborns. During the 1980s, there were fewer than 60 reported cases of congenital syphilis reported in New York City each year until 1987, when the number rose to 147 cases, and then to 257 cases in 1988. That is an indication of an overburdened system health care system in our inner cities.

Now let's look specifically at AIDS, Acquired Immune Deficiency Syndrome. As of August 1989, 28 percent of all reported cases of full-blown AIDS were either the result of intravenous drug use by itself, or in combination with homosexual and bisexual behavior, and 21 percent are the result of IV drug use alone.

If you look further at the causes of AIDS for different segments of the population, you find that blacks and Hispanics are more likely to acquire AIDS through IV drug use than are others. About 53.7 percent of those persons who have gone on to develop HIV infection and full-blown Acquired Immune Deficiency Syndrome as the result of IV drug use are black. Blacks account for about 12 percent of the population, but 53.7 percent of those who have become infected with this virus secondary to intravenous drug use are black. Hispanics make up about 8 percent of the population, but 25.7 percent of those who have acquired AIDS through IV drug use are Hispanic. To the extent that these two population groups are centered in our major cities, the connection between drugs, AIDS and the impact on inner city health care is obvious.

Not only are minorities more likely to get AIDS, but their life expectancy after they get it is much shorter. The average life expectancy after diagnosis of a white person with AIDS is two years. The average life expectancy after diagnosis of a black person with AIDS is 19 weeks. For women, the life expectancy is about 24 to 25 weeks. The primary reason for these differences is that AIDS in the white community is associated with homosexuality. These people are often from a high socioeconomic status, they have good health care and they have changed their habits. Individuals from the inner city and the minority

communities, who are part of the intravenous drug using population, are more likely to be in a state of denial, to have poor hygiene and poor socioeconomic conditions, and therefore their demise is much quicker.

Another thing this data tells us is that IV drug use is a growing cause of AIDS relative to homosexual behavior. Homosexuals have modified their behavior, but IV drug users have not. If we do something about intravenous drug use, we probably can significantly reduce the strain that AIDS is predicted to impose on our health care system.

What kinds of burdens does AIDS impose on inner-city health care. Again, you cannot look at this question without looking at all the health problems associated with AIDS.

For example, syphilis in an HIV-infected person takes a different clinical course than in an otherwise healthy person. In 30 years of practicing medicine, I had never seen a case of tertiary syphilis since I saw it in medical school. Today, I am seeing tertiary syphilis commonly among the addict population, because HIV infection has completely destroyed their immune system. When these people come into contact with the organism that causes syphilis, their deterioration is very rapid. They move very quickly from the initial infection to secondary, tertiary and even neurological syphilis, which is the last stage of syphilis.

The therapeutic efficacy of traditional syphilis regimens may be halted or reduced in these cases. Generally, we have treated syphilis effectively with penicillin and other antibiotics, but in many of these HIV-infected patients, we find that penicillin does very little good.

Tuberculosis is similar. Today, we can pretty much can cure tuberculosis, but we are now seeing new cases of tuberculosis infection associated with HIV which is much more serious. Most people who come into contact with tuberculosis have antibodies, and the tuberculosis is therefore not active, at least at first. People infected with the human immuno-deficiency virus, on the other hand, suffer a sudden breakdown and become symptomatic for the disease almost immediately. When we provide treatment, we find, just as with syphilis, that traditional treatments do not work. We can give anti-tuberculosis treatment to these individuals and they end up not being responsive.

Think about this in terms of crowded emergency rooms in major inner city hospitals. People in those emergency rooms infected with tuberculosis tend to be coughing and wheezing, and tuberculosis can be transmitted through the air. This means that to prevent the rampant rise of tuberculosis in minority communities, and particularly in the city

areas, we need to do something about the delivery system to move those people quickly out of the emergency room and into treatment.

Both of these problems – drugs and AIDS – are placing tremendous strains on our mental health care system. First, about 40 percent of the patients who are infected with the AIDS have some type of neurological affliction, and at present there are about 125,000 people reported to have AIDS, so that is a substantial number. Second, the relationship between drug use and mental illness is much stronger than most people might imagine. In fact, alcohol and drug abuse rank second as a cause of mental health admissions in our nation, and 71 percent of all drug abusers have a coexisting diagnosis with either a mental health disorder or alcoholism. Drugs and AIDS not only have an impact on the need for mental health care, but that impact is greatest in areas with large concentrations of minorities. About 30 to 40 percent of the people admitted to mental health institutions because of drug and alcohol abuse are minorities, which of course is much greater than their representation in the general population.

Of course, pediatric cases of AIDS represent another huge burden. Between 30 and 50 percent of the babies born to HIV-infected mothers are born with HIV infection and will go on to develop AIDS over time. Even where AIDS is not involved, we are beginning to see areas in which there are no beds available in pediatric wards because babies are just left there, the mother being addicted to drugs and the baby being born either deformed or with some other kind of abnormality associated with drugs. The health care system is not alone in being affected by this, because as these kids get out and go to school we are finding that they have learning problems. These young babies who are going to grow up and be major problem to society because they were exposed to drugs in the uterus of their mothers.

Taken together, all of these factors place a tremendous strain on the health care delivery system, and that strain is going to grow over time, for a number of reasons. First, as noted above, we are going to see an increasing correlation between AIDS and IV drug use, which means that we are going to have to be treating the symptoms of both of these problems, and all the diseases associated with them, together. Second, the number of AIDS cases is going to continue to rise for at least the next few years. In New York City, for example, we are projecting a near doubling of the number of cases between 1988 and 1993, from about 5,500 cases to nearly 10,000 cases. The same kinds of projections hold

true for most of our major cities. Third, thanks in part to improving treatment methods, the life expectancy of AIDS victims is increasing, and we have to be prepared to treat these people for longer periods of time, using treatments that are tremendously costly.

Effective response to the problems of drugs and AIDS will not only require us to do more of what we are doing, but to change the way we operate. For example, many primary care physicians and specialists are not trained to treat drug abusing individuals, so we need remedial training for these health professionals, not only in the inner cities, but also in the rural areas.

Some of the kinds of changes we need to implement include more routine testing for HIV infection upon admission to hospitals not to mention testing for tuberculosis and other drug-related diseases. Our clinical care examinations need to include looking at the integrity of the skin, which involves stripping the person down, looking at their bodies, looking in all the orifices, checking the lymph nodes, etc. We also need to be doing neurological assessment to check for neurological symptoms of AIDS or drug abuse.

Neither our drug treatment programs nor our acute care facilities are structured to meet the demands that drugs, AIDS and the associated health problems are placing on the system. We are not set up to treat alcoholics or drug abusers in the mental health system. Our drug abuse and alcoholism programs are not set up to treat mental health problems. And if you go into a hospital and ask for treatment for drug or alcohol abuse, you are likely to be told to go to a treatment center operated out of a storefront in some other location.

What we need to do is to bring drug treatment, alcoholism treatment and mental health treatment into the general health care system, and vice versa. There should be no drug treatment program started in this country unless it has an alcoholism component and unless it has a mental health component. Our drug treatment programs need to be transformed into a primary health care network, a sort of health maintenance organization for individuals who are given short shrift when they go into the classical health care system.

We also need to do a much better job of prevention and education, because doing something about the prevention of drug abuse would significantly decrease the problems of our health system in this country. Prevention needs to be aimed a the populations where the problem is worst. For example, we have infected babies because we have infected

women who give birth to them, and I believe we ought to be targeting women in these communities with education campaigns using brochures, TV and radio. You should not be able to turn on a radio station without hearing a message about HIV infection and drugs and sexually transmitted diseases.

We also need to target blacks and Hispanics. AIDS does not have a predilection to infect blacks and Hispanics. It is the the behavior in these groups, especially their exposure to drug abuse, that needs to be changed, and we need to be more aggressive in our prevention and intervention efforts in these communities.

If we can fashion an effective response to problems caused by HIV and drug abuse, there will be substantial benefits, including significantly reducing a considerable portion of HIV-associated medical, social and economic consequences. And that would have a very real and very positive impact on our ability to provide quality health care in our major cities.

High Noon in Alexandria

How We Ran the Crack Dealers Out Of Public Housing

James P. Moran Jr.

My motivation for entering politics 10 years ago had much to do with my commitment to civil liberties and government programs designed to help the less fortunate. Today, as mayor of Alexandria, Virginia, I still carry that commitment. But on March 22, 1989, something happened that profoundly changed my traditional liberal approach to crime and public policy.

March 22, 1989, was the day Corporal Charles Hill was killed in a public housing project known as "The Berg" at 316 Hopkins Court in Alexandria. I happened to know Charlie Hill. He was an outstanding police officer who was very much involved in making his racially and economically integrated community a better place to live for everyone. The best marksman on the force, he had just passed his sergeant's exam and had received his 23rd letter of commendation. But it was clear to those who knew him that it was his wife and kids who made this man so proud and disciplined. On the day of the shooting he had come home early to play ball with his sons Charlie, age seven, and Robbie, age three.

The experience of seeing his wife look up from her grief in the hospital that night and ask me "How do I tell Robbie and Charlie that their father will never come home again?" is one I will never come to grips with. It was the kind of experience that burns in your soul a resolve that it never be repeated.

Down the Drain

The story of Charlie Hill's death begins in a crack house that the housing authority was powerless to shut down. A young man in the housing project at 316 Hopkins Court, 16-year-old Eddie Jackson, was the principal crack supplier to the local junior high. Over half a million dosage units had been distributed from his residence in the previous

year. On March 16, while the police were trying to make a bust, Eddie flushed down the toilet $1,100 worth of cocaine that he was supposed to distribute. He wasn't arrested, because police have to knock on the door and announce who they are before executing their search warrant. Often, this delay provides enough time for the dealer to flush drugs down the toilet or wash them down the sink. You can't get a conviction on the basis of drugs being found around the rim of the toilet bowl or the sink drain unless someone admits to owning them.

Although Eddie wasn't taken into custody, he now couldn't get the money to pay his suppliers. At 3 P.M. on March 22, Eddie's two New York suppliers walked into his housing project and demanded payment for the crack that Jackson had been given. When he didn't have the cash, they left to pick up their enforcer. Within half an hour, a newly released felon from the District of Columbia, Jamie Wise, showed up with a sawed-off shotgun.

A Dangerous Felon Goes Free

Before I go further about what happened on that day in March, let me tell you a little bit about Jamie Wise. District of Columbia corrections officials actually had him listed as Jamie Black for the 20 years during which he had spent most of his time in their custody. He gave the name Black when he was first arrested as a juvenile. It was only after his death that his real name was discovered.

As an adolescent, Wise was committed to Cedar Knoll juvenile facility, which allows frequent home visitations. He committed increasingly serious robberies and burglaries during these "visitations." His punishment for these crimes was more time at Cedar Knoll.

He also developed an addiction to heroin by the age of 14, which evolved into cocaine addiction. After spending most of his adolescence in reform school, he emerged as a hard-core adult criminal who, when he wasn't incarcerated, was constantly involved in violent, drug-related rape, armed robbery, and assault.

In 1980, while on parole, Wise broke into a home, robbing and terrorizing the family. He was again paroled for four years to a halfway house in the District, from which he promptly escaped. His last sentence by a District of Columbia judge, for possession of drugs and weapons, was for one year, of which 90 days were to be spent in a halfway house.

So Wise, then 34, with over 30 felony convictions on his record, was released on February 16, 1989, to a halfway house in the District. Officials there say they were never informed of his previous escapes and parole violations; the judge in Wise's case refuses any comment. Upon his arrival, Wise took advantage of the fact that the residents were free to come and go – and went.

He went directly to the apartment of Darlene Williams, his common-law wife and mother of three of his six children, in the 800 block of Chesapeake Street, S.E. The first thing Wise did was to acquire a shotgun. He used the shotgun to commit two armed robberies, which in turn fed his cocaine habit.

The halfway house officials waited three weeks to notify the police of Wise's escape, even though Wise's address was well known to authorities. D.C. Councilman H. R. Crawford, who owned the apartment building on Chesapeake Street, told me that he had tried at least twice to get the police to arrest Wise for threatening residents with his shotgun while demanding crack cocaine. Attempting to apprehend Wise, the D.C. police knocked on his girlfriend's door; when nobody answered, they left.

At 10 A.M. on Saturday, March 18, the police were given a description over the phone of a shotgun-toting, halfway-house escapee known as Jamie living on Chesapeake Street. The woman on the phone said she would wait for the police to arrive and then point him out. The police never responded. At 3 P.M. on March 21, the same woman called again to request police assistance because "Jamie" was threatening people with his shotgun. The D.C. police never arrived.

A Hail of Bullets

The next day, March 22, Wise arrived at 316 Hopkins Court. The two suppliers had paid him $200 to make a hit on Eddie Jackson. Jackson's mother, her younger son, and two other street dealers were at home. Jackson's mother, Charlotte Durham, had been a public housing tenant all her life, paying $99 a month for her three-bedroom unit. She also had a $70-a-day cocaine habit, which she was feeding with her son's drug sales. Her other son, 13-year-old James, was a spotter and drug runner for his brother.

Instead of making a hit on the young dealer, Wise became distracted by his search for cocaine. He became so desperate for crack that he

started eating paint chips off the floor. He sent the 13-year-old into the neighborhood to find some cocaine. The kid told an adult, who called the police at 4:04 P.M. "There's a man with a shotgun that busted into 316 Hopkins Court. He's demanding drugs or he's going to kill them," said the caller.

Charlie Hill's SWAT team beeper sounded as he was playing ball with his sons. He rushed to the phone and heard the same message.

At 4:11 P.M. the Alexandria police arrived and confirmed that it was a hostage situation. They surrounded the public housing unit. Eventually the police got everybody out but the 16-year-old and Jamie Wise. Wise came out with a gun to Jackson's head.

Charlie Hill and his fellow officer Andy Chelchowski were stationed on both sides of the door. They put down their guns, asking Wise to put his gun down and let the hostage go. When Wise didn't drop his gun, it was radioed back to the control point that the two officers were now also hostages. The commanding officer gave the green light to a police sniper who had Wise in range.

The police sharpshooter shot Wise in the spine. He had so much cocaine in his system, however, that he was able to discharge his gun, shooting Chelchowski in the legs and Charlie Hill fatally in the face. Then Wise went down in a hail of bullets.

Two Years to Evict

I asked the housing authority how we could possibly have maintained a known crack house in our city's public housing. The answer I got was that you could not evict anyone from public housing unless she didn't pay her rent, committed fraud on her application, or admitted her income was above the eligibility level. (Not many tenants were going to admit the latter if their major source of income was drug dealing.) It *was* possible to evict someone after she had been convicted of a felony. But the courts have made it very difficult to secure sufficient proof to get a conviction for possession or distribution of drugs from a crack house. It's necessary to go in and find fingerprints in the cocaine, find it on the dealer's person, or get him to admit that the cocaine or other hard drugs is his. That seldom happens. The police told me that they have often found cocaine still around the edge of the drain in the kitchen sink, around the edge of the toilet, or in bureau drawers. But that is not enough evidence to get a conviction.

Even if a conviction were obtained, the Department of Housing and Urban Development (HUD) required you to go through an administrative grievance procedure that was costly, frustrating, and seemingly interminable. First, the housing authority had to put together a panel of three people to review the case. One person was appointed by the housing authority, and presumably would take a prosecutorial attitude. Another person was appointed by the tenant. The third person had to be acceptable to both groups. If the tenant didn't accept the third party, then you continued to negotiate until a third person who was acceptable was found. Our housing authority manager told me that this process generally took three to six months. Often it was used as a delay tactic by the tenant.

Once the panel was assembled, you went through a grievance procedure that was time-consuming and tedious. The housing authority had to present its evidence. The tenant had to see the evidence and have legal representation. The legal costs alone almost made it a prohibitively expensive process. According to HUD, throughout the country this grievance procedure took about nine months to a year. That was about what it took in Alexandria.

If you managed to prevail in the administrative grievance procedure, you went into the court system. And the normal court procedure could be appealed. Overall, it could take one to two years to get somebody evicted from public housing, even when she was openly running her unit as a crack house.

Essentially, our housing authority had given up. It just wasn't worth the effort. Better to wait and hope that the drug dealers missed their rent payments, because at least they could be evicted immediately for that.

Kemp's Fast Response

I wanted to make sure that our housing authority didn't give up, that it would be worth its effort to try to get known drug dealers thrown out of our projects.

I asked for a meeting right away with HUD Secretary Jack Kemp. I got that meeting the following Monday. At HUD we presented as strong a case as we could that the Virginia constitution guaranteed due process through its judicial system. If HUD would allow us to bypass the administrative grievance procedure, we would pay for the evicted

tenant's attorney and any appellate costs, and we would provide an adequate evidentiary proceeding.

I have spent six years in the federal government, and then several years on the staff of the Senate Appropriations Committee, and I have never seen quicker action than we got from Secretary Kemp and Frank Keating, the general counsel for HUD. Frank Keating had been a prosecutor in Oklahoma and he really understood the problem. HUD had tried to get regulations changed the previous year, before Kemp's tenure, to enable them to evict drug dealers, but tenants' rights organizations had defeated them.

HUD gave us the first waiver in the country to evict drug dealers without going through the administrative grievance procedure. As of April 1, 1989, we were allowed to evict public housing tenants if there was a "preponderance of evidence of criminal activity." HUD has since waived the eviction grievance procedure in 39 states and the District of Columbia (although few areas are actually taking advantage of the waiver). At my request, the Alexandria housing authority also withdrew its requirement that we get a felony conviction before evicting anyone.

100 Households Evicted

Let me explain how we determine the existence of a crack house, so that you understand how careful we are to protect the innocent. First, we make a controlled drug buy. Often we send in someone who has been involved in the drug trade in the neighborhood, and who wants to get off light, or for one reason or another is cooperating with us. He goes into the house with marked money and nothing else. He comes out with drugs and no money. To make sure that this is not a one-time thing – that you can regularly buy drugs in that housing unit – we make such buys on more than one occasion, usually separated by two or three weeks.

After we have made more than one successful controlled drug buy, we go to the magistrate to get a search warrant. Only if we find drugs and drug paraphernalia in the possession of the tenant, or have reason to believe that the tenant is aware of the drugs found in her home, do we go through the eviction procedure.

Using this procedure, over 100 families involved in the drug trade have been evicted from public and private housing in the city. We have

been legally challenged three times. The eviction has been upheld each time.

We have applied the same aggressive attitude toward private housing that we have toward public housing. With the help of the apartment owners' association, we have put clear, specific language in every lease making the tenant subject to immediate eviction if "a preponderance of evidence of criminal activity" is presented by the police to our prosecutor, who then notifies the landlord. We then put an asterisk next to the evicted tenant's name in a computer base maintained by the landlords' association so as to deny them housing elsewhere in the city.

Holding the Family Accountable

Once we have enough evidence for an eviction, our policy is that the whole family goes. That's another controversial issue that has had a lot of political ramifications. ACLU lawyers, Legal Aid, and Congress feel strongly that the whole family should not be evicted, and have even brought suits or passed legislation that would prevent family evictions. They're wrong for several reasons.

If a house is being used as a distribution center, the whole family is nearly always aware of it and therefore is complicit in, if not supportive of, the crime. One of the most effective deterrents to criminal activity is family control – even if it is coerced. If you threaten to evict only a son or a daughter who is dealing drugs, the parent has limited incentive to stop her child's drug dealing, especially since she generally shares in the profits.

In many cases the parent is the offender. But cities are not going to evict the parent and leave the kids in the housing unit alone. If the parent is incarcerated or is so addicted that she can't be a responsible parent, we take the children and put them in foster care. If the parent subsequently proves to the family court and the social worker that she is neither addicted to nor selling drugs, the children are returned.

Many of the evictions have been caused by the drug activities of male visitors who supply the tenant's family with drugs and money in return for the use of the apartment. Without the threat of eviction, there is little incentive for the female head of household to keep these dealers out.

Our ultimate purpose is not to convict or even to evict drug dealers. It is to deter the devastation that open drug-trafficking wreaks on a

neighborhood, by letting everyone know that there is a very real punishment associated with drug dealing in Alexandria – a punishment far more severe than the few months generally served by multiple-offense drug dealers. We have found that evicting an entire family with a "preponderance of evidence of criminal activity" is the most extreme penalty we can assess.

Eddie Jackson, the young dealer involved in the murder of Charlie Hill, has been sentenced for distribution. His mother, Charlotte Durham, has been prohibited from setting foot on public housing property, and her children have been placed with her mother, who lives next door. Mrs. Durham, who is still addicted to crack, is again pregnant and has appealed to the city's Human Rights Commission to negate her separation from her children. The city of Alexandria has refused to rescind the separation order. We are considering charging her for the child abuse of her fetus.

After we had started our evictions of drug dealers and had won our first appeal, Congress put language in the Dire Emergency Supplemental Appropriations Act of 1989 that said that you cannot evict someone if any member of their family would suffer an adverse consequence as a result of that eviction. We continued in a *sub rosa* fashion, and fortunately, HUD got the language reversed last November. But that was an example of what local governments that want to rid their public housing units of known drug dealers have to deal with. This kind of legislation is irrational and irresponsible.

A related question deals with the placement of people into public housing. There is a federal regulation that requires that the first people placed in permanent housing come from homeless shelters. Another well-meaning regulation. Everybody, on the face of it, would say, "Oh, that's a real good idea. If you don't have any shelter, you should be the first to be placed in public housing." Wrong. We found that of the first 14 people from our homeless shelters placed into permanent public housing, eight were addicted to drugs and/or dealing drugs.

The other tenants in the neighborhood said, "What are you doing to us? You are destroying our neighborhoods by putting these people into our communities and we have no say in it." I would like to require that tenants be tested for drugs before they are placed into permanent public housing.

Seizing Buyers' BMWs

One of the biggest problems in our housing projects has been the growth of open-air drug markets. Drug sales in the United States generate about $150 billion in gross income a year. That kind of money doesn't come just from low-income ghetto neighborhoods. It comes from more affluent suburbs as well. And many buyers from these suburbs come to buy at open-air markets in the projects. In fact, if you watch any of our worst neighborhoods, you will see automobiles from the suburbs pulling up to make their drug transactions. To fight this problem in our public housing projects we have obtained state authority to seize the automobiles of these buyers.

Recent court decisions have nullified arrests of known drug dealers, searches of whom have uncovered significant amounts of illegal drugs, because the arresting officer didn't actually see the small rock of crack being exchanged between buyer and seller. Street dealers now openly transfer drugs in a clenched-fist fashion, even if the police are standing nearby. This past May, Alexandria passed a very restrictive definition of loitering that will help police counter these "criminals' rights" court decisions. Loitering is now defined as remaining in an identified drug area for longer than 15 minutes and making hand contacts with two or more individuals on separate occasions lasting less than two minutes each, so as to pass small objects in a covert way.

The ACLU, the NAACP, and Alexandria's Human Rights Commission are suing the city over this ordinance as this article goes to print.

Safety as Civil Liberty

It is phenomenal to think that we have evicted over 100 drug-dealing households in our city. And that's just in one year. It should have been done a long time ago. I have gotten very positive responses from community leaders on the evictions. There is an improvement, a dramatic improvement, in some of the five neighborhoods that were under the control of drug dealers. We have reclaimed all but one and a half of these areas today. You can now walk your dog at night and sit on your porch in three of these previously drug-infested neighborhoods.

Fighting the devastation of drugs at the individual, family, and neighborhood levels is an objective worthy of our best efforts. It should motivate us as a society to come together, to act logically, and to work

diligently to save our family members, friends, and neighbors from addiction to hard drugs and easy money. Unfortunately, these efforts are made much more difficult by those who, in their well-meaning desire to defend their ideas about civil liberties, trample the rights of the majority of individuals in drug-infested neighborhoods. Of all the public benefits we can provide people in low-income areas, none is more beneficial than a safe neighborhood. Law-abiding citizens have no civil liberties when our laws protect the rights of drug dealers to poison children, to offer more money than an honest job can ever pay, and to terrorize households into criminal complicity.

It is true that our civil liberties are at stake. It is also true that unless we exercise common sense and judicial responsibility now, they may be lost forever to the citizens who need them the most.

Should Welfare Mothers Be Tested for Drugs?

Robert L. DuPont, M.D.

I favor universal, regular drug tests as a condition of receiving public assistance. That is a shocking concept to many, but it is rooted in two fundamental beliefs.

First, I believe that this is a *helpful* initiative. It is not punitive or hurtful. It is a matter of saving lives, saving families, and saving communities. My support for drug testing of welfare recipients is part of my caring commitment as a physician specializing in chemical dependence.

Second, my support is based on the belief that when someone receives a social benefit, there are corresponding responsibilities. Many people have been harmed by separating entitlements to public services from personal responsibilities. The proposal I am offering is in everyone's best interests, not just the taxpayers who are footing the public assistance bill, but also the recipients of public assistance, their families, and their communities.

One of the emerging concepts of drug abuse epidemiology is that the drug problem is gradually separating itself into two different problems. One way to understand this separation is to distinguish casual users from hardcore users. The emerging distinctions can also be characterized as middle class and lower class, or as light users of soft drugs, such as marijuana, and heavy users of hard drugs, such as cocaine and heroin.

Many poor people use "soft drugs" and do so infrequently, and many rich people use hard drugs intensively, and yet there is a nexus between income and drug use. Even though it is not complete, that nexus is reflected in the underlying reality that the poor lack the opportunities that the rich take for granted.The poor are, with respect to drugs, cheated, hurt, and victimized by living in enabling communities, largely supported by public assistance. Separating work from income and

failing to require tests for drug use are central components of this tragic enabling.

How does that happen? The effect of enabling actions, including those meant to be helpful, is to victimize the poor and needy and to add to the pain and suffering that they and their families experience. It is my observation that it is precisely the people who are the most intellectually devoted to helping the poor who most contribute to this unwitting victimization from drugs and alcohol.

We need to extend to those people who are receiving public assistance the behavioral safety nets that the middle class often take for granted but are not used in many poor communities. That means "raising the bottom" on drug abuse; it means "tough love."

Before explaining why I think this is so important, let me provide some context about my personal experience and how I came to these conclusions. I spent thirteen years working in the public sector in programs designed for the poor. I learned about drugs working for the District of Columbia government and subsequently for the federal government. I took my role as a public servant seriously, and I greatly appreciated the opportunities that I had, particularly in the District of Columbia.

For twenty years I have maintained a private psychiatric practice, which became a primary activity when I left government service in 1978. In this role I have worked with many families in Montgomery County, a very different group of people from the poor people with whom I worked earlier in my professional life. Many of them are quite well-to-do, even though they do not think of themselves as wealthy. I have learned that drug and alcohol problems are "equal opportunity destroyers," affecting the rich and the poor with equal cruelty.

In addition to practicing psychiatry, I have been involved in a number of other activities since 1978, including assuming the position I still hold of president of the Institute for Behavior and Health, Inc., a nonprofit research and policy organization. I have focused in recent years on the problems of drugs in the workplace where we have seen enormous progress made in terms of dealing with the drug problem. My recent article in *Policy Review* magazine (1) supported random drug testing in the workplace. I must point out, just in case there is any concern that I am somehow singling out welfare mothers for a punitive program, that I have advocated the same approach in the workplace in the private sector, including the testing of physicians, accepting that

the tough love of random, mandatory drug tests is part of one's responsibility as a citizen (2,3). I am particularly proud to have worked with the Johns Hopkins University, which announced its intention to be the first medical school and hospital in the country to implement universal random drug tests for the medical staff. I strongly support this courageous step.

It is easy to try to draw lines between liberals and conservatives on the drug issue, and to think that one group is right and the other is wrong. After many years in this field, I have concluded that looking at the drug issue with a political or ideological filter is likely to be misleading. Although many of the opponents of the tough antidrug programs that Mayor Moran discusses elsewhere in this volume are politically liberal, there is a strong contingent within the conservative community that opposes drug testing and other tough actions against drugs. On the other hand, there are many people in the liberal community who are educated about chemical dependence and who do take tough positions. They have concluded, as I have, that drug abuse is the modern slavery and that strong, community-based action needs to be taken to end it. My position is that we need to be tough on drugs. We need to reject drug use in all areas of society, including in the economic segments of our community. I am prepared to enlist help from any source to get that job done. I do not see the issue of tough antidrug programs in any kind of simplistic partisan or political terms.

Why do I believe that recipients of public assistance should be tested for drugs? Let me begin by providing a little background on how chemical dependence works (4). Drugs are chemicals that affect the brain and produce pleasure. They produce an experience the user wants to repeat. This is a biological reality. It does not have anything to do with whether you are rich or poor, or black or white, or on public assistance or a well-to-do physician. This is a reaction of the brain to the presence of the chemicals, which produces an effect called "reinforcement."

There is a strong and long-established connection between drug abuse and youth. Lest you be confused about it, this connection also exists for legal drugs, such as alcohol and tobacco, where, just as with illegal drugs, the peak rates of use are in the 18- to 25-year-old population.

Research shows that chemical dependence runs in families. (Everyone is vulnerable to drug or alcohol abuse because it is a

universal vulnerability, but one's susceptibility is relative in terms of genetic background.) People who have parents or siblings who are chemically dependent are more at risk for chemical dependence both on a genetic basis and on a behavioral basis.

The biological reinforcement to drug use is universal and powerful. That means that a serious drug problem will exist as long as people are exposed to drugs in a setting where they think they can get away with using them. If people are exposed to drugs in an environment where there are no immediate negative consequences for drug use, then large numbers of people will use drugs. Once they use them, a large percentage will be seduced into drug dependence. The hallmark of addiction occurs with the loss of control over drug use, and the associated sacrifice of other values, including family and community values.This process, this disease of chemical dependence, has nothing to do with social class or income.

Chemical dependence has been called cunning, baffling, and powerful (5). It is also lethal. It is not self-curing like the common cold. It is progressive. It leads to the destruction of the individuals, families, and communities.

Why do we now have an epidemic of drugs in this country? Because our social response to drug use has been to say, "You do your thing and I'll do mine." Drug use has become a personal decision that leads to exposing millions of people to the lure and the consequences of drug use. Now we are beginning to see a reduction in drug use in the United States because we are seeing a concurrent reduction in the tolerance for drug use in society.

Why is the drop now greater in the middle class than the lower class? The middle class now is much more intolerant of illicit drug use, especially the use of heroin, cocaine, and PCP, than the lower class. The greater tolerance for illicit drug use and its negative consequences in the lower class reflects the factors I have mentioned, including the profound enabling impact of our public assistance programs.

This is the "Environmental Approach" to drug abuse prevention because it focuses on the environment in which decisions to use and not to use drugs take place. An environment where drugs are widely available and which tolerates drug use is an environment that promotes and enables drug abuse. An environment that makes drugs scarce and that rejects drug use is an environment that prevents drug use. Note well that I use the words "drug use" rather than "drug abuse." To focus

only on drug abuse is to tolerate and therefore to encourage drug use which leads inevitably to escalating drug abuse. Drug use is the environmental issue that must be faced without ambiguity or equivocation (6).

The number one symptom of chemical dependence is denial. Denial exists throughout society – in individuals, in families, and in communities. People simply do not want to know about drug use. Denial is not just a matter of ignorance, and it is not a matter of bad intentions. Stripping away that denial is a number one objective for both prevention and recovery.

How does recovery work? How do you start to get well from a chemical dependence problem? In one sense, recovery is a fairly simple process. It begins when people "hit bottom"; i.e., when they experience a consequence to their drug use that is painful and that forces them to confront their drug problem. In no other way does recovery begin. It starts when someone says to the drug user, "You must stop or else," and means it.That is the beginning of getting well.

In America today, we have high bottoms and low bottoms.What does that mean? It is an important concept because it has to do with how many negative consequences there have to be before there is intervention to stop drug use.

Here is where we get to one key difference between the poor and the middle class. People who must work and who have active families do not take as long to hit bottom as those who lack these support systems. They have higher bottoms because their families, communities, and employers are less tolerant of drug use. One of the major thrusts of the drug testing proposal I am suggesting for public assistance is to raise the bottom for the poor, so that life does not have to be so desperate before something is done about drug use. For the poor, the criminal justice system is the bottom.This is a low bottom. For the middle class, the usual bottom is provided by the family and the workplace.This is a higher bottom.

How do people recover from drug use? Spending money on doctors, social workers, and psychologists does not cure chemical dependence. It does not matter whether you have millions of dollars or the most expensive treatment in the world.You cannot get well by going to an expensive treatment program.

What happens when you go to the Betty Ford Center, to Hazelden, or to any of the other excellent, prestigious chemical dependence treatment programs? Let me tell you a little secret: Those expensive

professional drug treatment programs did not work in the past. Now they do work for many people. Today these programs that do work educate and link individuals and families to the 12-step programs: Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Al-Anon. People get well and stay well by going to meetings that are free to everyone, rich and poor alike.

My richest chemically dependent patients in Montgomery County, Maryland, who often want to buy recovery, find that it is not for sale at any price. They cannot send their assistants. They cannot hire therapists to cure them. They do not get well from chemical dependence unless they go to 12-step meetings in a community of recovering people, day after day after day.

Those free 12-step programs are culture-specific to every single subculture in the United States: black, white, rich, poor, medical, welfare, criminal justice.There are 12-step programs for all segments of the American population. These programs are a modern miracle in our midst, and most Americans have not yet noticed them (7).

With this background in mind, let me explain why I believe we ought to be testing recipients of Aid to Families with Dependent Children (AFDC) and related public assistance programs for drug use.

The first reason is to protect children, especially babies. One in ten mothers of child-bearing age uses illicit drugs. The most recent estimate is that last year we had 375,000 crack babies born in the United States. In some urban hospitals, 25 percent or more of the babies born are born to mothers addicted to crack and other drugs. In fact, the term "crack babies" has become a common and a horrible phrase, a kind of headline for the drug problem, only five years after crack was first introduced into the United States (8,9,10).

What are the consequences of maternal drug use for infants? One recent study showed that 33 percent of the babies born to mothers using cocaine were premature, compared to three percent in a control population matched for social class (8). Hemorrhaging at birth serious enough to threaten the life of the mother or the infant was reported in 15 percent of all births by crack users. The figure in the control group of mothers who did not use crack was zero. Of babies born to crack-using mothers, 15 percent of the crack babies died of sudden infant death syndrome, compared to one percent for the control population.

What happens after these babies are born? One study that followed crack babies 18 months after birth showed that many did not establish

connections with their mothers, did not learn normally, and did not behave normally compared with the matched control group (8). My hope is that crack babies will help our society crack the denial about the connection between maternal drug use and the welfare of infants. This can be an opening wedge to addressing many of our drug problems (11). The babies are not the only beneficiaries of a strong antidrug program in public assistance. The mothers themselves will benefit along with their children. Communities now burdened with the myriad costs of drug abuse also will benefit. This is a caring, humane, public health proposal aimed at prevention and at earlier identification of problems with drugs. It is not a law enforcement or a punitive program. This proposal is not based on the assumption that recipients of public assistance are the only Americans with serious drug problems or that most recipients are drug abusers. It is based on the belief that there is a serious drug problem among recipients of public assistance and that those who conduct programs to help these needy people – adults and children – must help to prevent and to overcome those drug problems.

Aid to Families with Dependent Children and related programs are a caring, needed, vital, positive response focused on the needs of families, and most especially on children. There are 11 million people receiving public assistance through these programs, in 3.7 million families. This is a joint federal and state response, started in the 1930s to help widows raise their children with some ability to support them financially.

Today, the typical welfare recipient is a 25-year-old single mother of two. The program operates in both urban and rural communities. There are more whites on welfare than blacks. Roughly half of the welfare rolls turn over quite actively. Most people use AFDC as a temporary means of support. The other half of the AFDC rolls, however, are long-term users of AFDC, and 40 percent are what might be called generationally dependent on public assistance (12). In fact, an unwed mother who is a high school dropout and is unemployed has a greater than 50 percent chance of staying on public assistance for ten years or longer.

The impact of the AFDC program in the United States is tremendous. According to a study by the U.S. Census Bureau, from 1983 to 1986, over a 32-month period, 15 percent of the entire U.S. population received some assistance from either AFDC or food stamps. The percentages that received half or more of their total income from

AFDC during that period were 4.1 percent for whites, 21.1 percent for blacks, and 14.3 percent for Hispanics. Age is, of course, an important factor. Of all the children six years or younger in the United States, during that 32-month period, 30.1 percent received public assistance. Of those under the age of 18, 26.6 percent received AFDC or food stamps12.

Those numbers tell us that if we are going to have a drug policy that reaches families most in need – a family policy and a prevention policy – we are going to have to deal with public assistance.

How are welfare and drugs related? First, there are, as far as I can tell, no surveys about public assistance and chemical dependence. There are no studies that have looked at the question of how many welfare mothers and how many of their children are chemically dependent. That is an example of serious and destructive denial. That is an example of not knowing information that is vital to the humanitarian purposes of those public assistance programs.

Even without specific data, we do know a lot about the relationship between drugs and welfare. First, we know that people who are using drugs do not function well. They often fail in their family relationships, in education, and at work. Drug use by mothers, fathers, and teenagers causes economic dependence. One of the main reasons people fall into poverty, and often stay there, is because of chemical dependence.

Second, the lifestyle of welfare recipients promotes drug abuse. It is an enabling social system. People receiving public assistance have time to use drugs, and they are protected from the consequences of their drug use by a social system that does not look for chemical dependence or intervene to stop it. Our current welfare programs are organized in such a way as to promote the problems of chemical dependence.

If that sounds harsh, let me tell you that many of my patients in Montgomery County who are rich have exactly the same problem. Their wealth insulates their children from the consequences of their behavior. It leads to tremendous problems of chemical dependence in those kids, as the consequences of their bad behavior are mitigated by what is essentially a parental welfare system. The chronic dependency that this syndrome breeds in the upper classes is awesome. It does not end when the kids reach the age of 18 or 21. The chemical dependence in that situation, where the kids are protected from the consequences of their behavior, often goes on for a lifetime. It is not just poor people

shielded from the consequences of their drug use who suffer from drug abuse.

In recent years many families in the middle and upper classes have discovered "tough love" – the absolute requirement that all family members confront the consequences of their drug use. Often this means drug testing. Our current welfare programs are an enabling system. They are organized in such a way as to promote the problems of chemical dependence.

What do I propose? My basic concept is that we should apply current workplace drug testing policies to public assistance. That model includes pre-employment testing, for-cause testing, post-treatment testing, and random testing. Positive drug tests result in loss of benefits as well as referral to recovery programs, including 12-step programs. Employee Assistance Programs (EAPs) help chemically dependent people, their families, and the social organization work together for their common good. This model is succeeding in the workplace. It can work in the high-risk environment of public assistance. It should be applied to mothers and to children over the age of 8 or 10. It should be both tough and fair. The goal of this model program is not to punish, but to prevent problems with drugs and alcohol and, if prevention fails, to ensure that effective intervention takes place.

A first priority is for additional study of the connection between public assistance and drug use. We need both cross-sectional and longitudinal studies, using both hair testing and urine testing, to know more about the drug-using patterns of people on public assistance, including both the mothers and the other family members reached by public assistance. I would be happy to be shown wrong in my assumption that a large percentage of these people have chemical dependence problems. But we need to know the facts.

Second, we need demonstration projects. Contemporary public assistance programs present wonderful opportunities for experimentation because of their rich diversity. The fact that these programs are operated at the state level allows for variety, which is a good way to develop better approaches. We need to establish a variety of state models to find out what works to prevent and to overcome chemical dependence.

What is likely to work? First of all, drug screening should be conducted at intake for people entering the public assistance rolls; the equivalent of a pre-employment test. This drug testing is needed to

establish whether potential welfare recipients have drug problems, in the same way that we now screen new public assistance recipients for education or job skills.

Second, people who are already on the welfare rolls should be tested. They need to be tested both on a "for-cause" basis, as is common in the workplace, and on a random, unannounced basis. As in the workplace, the major reason for drug testing is not to punish people, it is to give people a good reason not to use drugs – a good reason to get straight and to stay straight.

Third, we should not only test the adults who are on public assistance, but also the children, because these children are extremely vulnerable to chemical dependence.

Fourth, and this is the most easily misunderstood part of the program I propose, we need to determine what will be done with public assistance recipients who test positive for drug use. To answer that question, remember that this is a preventive program. A preventive program will not work unless it is tough, because the pull of drugs is too strong.

The first response to a positive test is to refer drug users to the equivalent of an Employee Assistance Program, a counseling place that is made up of both professionals and recovering drug users. We need to get the people who test positive connected to that community of recovery. That can be done with the first positive test, without any sanctions.

Second, we need in public assistance what in the workplace is called "progressive discipline" with "job jeopardy." The end of this process has to be tough. Consequences for continued drug use could start by reducing the amount of public assistance money for the person who tests positive according to a formula.

Third, if the person does not stop using drugs after these consequences, the public assistance check can be given to another payee, such as a grandmother, or the children can be removed temporarily from the home. That is a hard step, but my experience tells me that such a child has no chance of doing well as long as the mother is using cocaine or other drugs. To me, if the mother continues to use drugs despite help, the children definitely should be removed from her care. They will be better off.

We need to encourage demonstration projects to resolve the question of what happens to children if they are temporarily taken out of the home. Is it possible to have temporary, supervised assignments to

a caregiver who is in a recovery program? Can the local Narcotics Anonymous meeting provide volunteers to help take care of children temporarily whose parents are chemically dependent?

The objective of this proposal, however, is to separate the mother from the drug, not the mother from the children. That is the goal of being tough.

Fourth, a civil commitment procedure can be established to require that the person who repeatedly tests positive for drugs becomes drug free. There are those who do not like that idea, but to me it is a way of saying, "I care enough about you to make sure you are not going to use drugs."

The simple summary of these steps is: You do what has to be done.

What about the mother in public assistance who is using drugs while pregnant? I think of those as *in utero* crimes. In these cases, we should care for the mother and do what has to be done to help her stop using drugs. I would enlist the help of people who are former drug users themselves. But, ultimately, we have to say, "This behavior is not acceptable." If that means that we have to have some kind of containment to keep the pregnant mother from using the drugs, I support that in the interests of the baby, the mother, and the community which would have to pick up the pieces for many years if we are not tough enough.

Many people do not understand just how gripping drugs are, especially crack cocaine. The idea that giving someone a pamphlet or attempting to educate them is going to get them to stop using drugs is not realistic. The idea that giving a drug user a place to live and financial support is going to get them to stop is not realistic. A training program or a job will not work either. These benefits – these humanitarian efforts – can only work if they are coupled with strong, effective, "no drug use" programs. The term in the middle class is "tough love." It means saying to the drug user, "I care enough about you to see that you are not going to continue to do this."

Does that sound like George Orwell's *1984* here in 1990? To some people, I am sure it does. Such a program would be a failure if its punitive aspects were emphasized. To me, it sounds like a caring approach that offers effective assistance to people who urgently need it.

The ultimate goal of the effort that I am proposing – the goal that must be held sacred – is the humanitarian, compassionate objective

to help people, and especially to help children, in the welfare-dependent community. Can we do less and meet our responsibilities to these families in need?

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PART V

CITIZEN ACTION AGAINST DRUGS

Community Policing in Tulsa

Drew Diamond

In 1984, as a patrol commander with the Tulsa Police Department, I was involved in doing some long-term planning for the police department. We tried to step back and take a look at where we were, and where we were going. One of the things we did was take some surveys of how people viewed the police.

Interestingly enough, one of the things we learned in the course of that effort was that we were highly regarded throughout the community – more so in some parts of the community than in others, but overall, our surveys told us that people felt we were doing a reasonably good job.

When we looked at ourselves, however, we began to realize that we if we tried to maintain the *status quo*, and rest on our laurels, we could be in trouble by 1990. I am glad to say that we chose not to do that. Instead, we adopted, as a philosophical position, the concept of community-based policing. That was our term. Others refer to this concept as neighborhood policing, community policing, community-oriented policing, but it is all the same idea.

There had been a tendency, in Tulsa as well as elsewhere, for police to operate from the perimeter in urban areas – to go in, clean up a neighborhood, displace the crime, and then retreat. But what happens next is that the crime comes back in. We clearly felt, and still feel, that approach is not consistent with our philosophy.

We set out to change the Police Department to have more of an impact on the community, because we felt that in the long run our success would depend on our ability to impact community problems related to crime, such as drug and alcohol abuse, that we were going to be faced with over the next ten to twenty years. So, we changed the Police Department. We redesigned the way we operate. We changed a lot of things about the way we deliver our service. We changed our training. We took a hard look at whether or not we were serving the most vulnerable people in our population with the highest quality of service that we could give them. We found ourselves wanting in that

area, and we felt strongly we needed to fix that. And all of these changes are encompassed in the idea of community policing – an idea which is not a new idea, by the way, but a very old one.

What community policing means is taking our technology, our interpersonal skills and all our other capabilities and putting all of that together with the people we serve. It means having a sense of serving, as opposed to being an entity unto ourselves. This is the framework we have brought to our efforts to address the crisis of drug abuse.

As we began to change the way we deliver service, we began to to network socially with everyone in our community. We have a Police Department with 850 employees, and I have 850 of the best community organizers and grassroot networkers anywhere. We do a good job at that. For example, there are 52 United Way agencies in Tulsa. My officers sit on the Board of Directors of 42 of those agencies, and we are involved in all 52. And, we do more than just show up at meetings. We are involved on a constant basis.

We translated this networking into problem solving – solving problems in conjunction with the community itself. And working together, we asked, "What would work for us? Whether it be public housing, or neighborhoods, or downtown, or schools, what are those things that work for us? And what are the unique things about us and about our neighborhoods that need unique approaches?"

We told our officers, and the community, that once we identified a problem, we would all work together to come up with the resources to solve the problem. We felt, and still feel today, that there is no problem that cannot be solved in this way.

In contrast to some places in this country, we did not spend the last few years looking down at our feet, feeling that nothing can be done, and looking for somebody to come in on a horse and rescue us. We felt just the opposite. We had problems, and we still have problems, but they are problems that can be resolved.

With respect to drugs, we looked at four problems, and took on all four of them: Education, enforcement, treatment, and research. My belief is, and has been, that we have to do all those things concurrently, on an ongoing basis, and in a coordinated way.

We cannot get ourselves into a situation where we put all our resources in the enforcement basket and not enough in education, then we jump over to education, then jump over to treatment – all the while ignoring research.

This approach, in conjunction with the concept of community policing, as produced very good results. For example, we have been able to virtually eliminate street corner drug dealing in Tulsa. Similarly, we have virtually eliminated drive-by shootings, which was a problem we began having two years ago related to people watching television and learning that this was the way they could solve fights. We accomplished that, and surveys are showing we have also accomplished a reduction in overall drug use, by applying this concept of community policing.

Let me say that this is not an entirely easy concept to implement. You cannot just do it rhetorically, or for six months while the TV cameras are there, and make everybody feel good and then go home. This is intensive work that goes on from day one and cannot stop. It has different levels of intensity, but you can never retreat. Once you impact a neighborhood positively, you cannot retreat from it completely.

It also requires long-run changes in the Police Department itself. I felt when I started putting us on this path, and then when I became Chief, and certainly feel now, that this approach would take ten to fifteen years to take hold. These are cultural changes within the Police Department. These are changes within neighborhoods. People who expect that these changes will take place in a year, or two years, or three years, are sadly mistaken. These are generational changes.

It is also important to allow room for failure. We think it is important to try things and give them a chance to succeed. But, it is also important that, once you recognize something is not working, you must be ready to go on to something else. A lot of things we have tried have not worked, and we have gone on to other things, without going backwards.

The main thing we have learned, which is what we believed when we started down this road, is that this is a nation made up of communities, cities made up of neighborhoods, and what matters more than anything is a sense of caring. We had to bring that back within the Police Department. We had to bring it back within the community. We had to say that, regardless of where you are in this community, you can reach out, you can get direction, you can get help, you can be part of the solution, and we are serious enough about that that we will be there to help and encourage.

As I indicated above, this approach is producing results, and we are very pleased with it.

Neighborhood Drug Patrols

James Foreman

I represent the Fairlawn Coalition, a neighborhood group in the Southeast area of Washington, D.C., which is one of 52 groups participating in a city-wide organization called the Metro Orange Coalition. This organization has been in existence for less than two years, but in that time, over 5,000 people have joined and participate today in what we do on the streets of Washington, D.C.

What we do is move drugs out of communities, and we do it in such a way as not to involve people in any kind of physical contact or any kind of violence, verbal or physical. We separate drug dealers from drug buyers.

We found out long ago, when we first started Fairlawn Coalition, that we had a drug problem within the community because we allowed it to happen. We allowed the drug dealers to come in, set up, control the streets, control the activity in the community and control the movement of the people. We did it by doing nothing. The only reason they took over is that we did nothing to stop them from taking over.

A group of concerned people within the community got together to talk about that. Initially, there were only about fourteen people involved, including Reverand Dalton, who is now with the Southern Christian Leadership Council in Atlanta. We decided to do something, but we had no idea exactly what that something should be. We contacted everybody we could think of to find out exactly what to do to remove the drug problem from the community, and we got all kinds of ideas that would not work with the our group which composed of senior citizens, mostly female, and a few men.

The advice that we got was for what I call a Rambo-type approach, and we could not do that. And we found out that there was nothing else in existence that we could do, except rely on the Metropolitan Police Department. But we already knew that what the Metropolitan Police Department would do is come in and then leave, and the drug problem would come right back in behind them.

So we decided, out of the clear blue sky, just to go into the streets. We said, "If they are there, then we will be there, too." So we left one meeting on a Tuesday night, January 10, 1988, and decided to go into the streets.

Initially, we received a lot of abuse. We were, at that time, known as the church people, and we received out and out verbal abuse, but that did not stop us. We came back again and again and again. Then, one night while we were out on the street, one of the members' daughters came out on the street with a video camcorder and started filming the group of citizens on the street. That was when we learned that the fellows on the street who were buying and selling drugs did not want to be filmed. They ran.

So we went back in to our meeting, and we sat down and talked about this, and we said, "We can utilize this tactic." We also realized that the groups that were supporting the drug market were people driving their cars in from from Maryland and Virginia. There were very few D.C. tags driving through the drug market, although there was walk-in traffic from people who lived within the the area. But it was the people who came in cars who were the big time buyers. They would buy two, three, four, five, six hundred dollars worth of drugs at one time. We found out the time that they usually come in to buy was between the hours of 7:00 and 11:00 in the evenings.

Once we found that the people on the street did not want to be seen, we decided that we would see to it that they would be seen. So, we got binoculars, 35 millimeter cameras and video camcorders. Initially, we utilized what the people had within their households, and they brought them out onto the street, and we found out that it worked pretty well.

That was when we decided we had to be known as a group, to be visible, and to be known on the streets to all elements, including the police, the people who were dealing drugs and the people who were coming to buy drugs. We decided that we wanted to get a color that would signify that this group was on the street at this particular time.

We came up with the idea of wearing bright orange hats, and that is what we wear now. They are very bright – you can see them twenty blocks away.

We tried from the beginning to get the Metropolitan Police, the church involved, and the politicians involved in this effort. We got Reverend Dalton involved, but no other pastors. They did not come

out. They did not participate. Evidently, they did not care to be involved in what we were doing.

At the Metropolitan Police Department, we caught the ear of Deputy Chief Joyce Leland and Captain Claude Behilier. They were the only ones who would listen to what we were saying and took an interest what we were trying to do. They came out on the streets with us, and participated in our meetings.

But initially, this one Captain was the only person who helped us. The rest turned their back on it. They did not want to be a part of it. They did not want to spend their time being involved with the community. He did, and it worked.

As for politicians, they came in to seek support for their own special agendas. We found that out that early, so we said "no politicians." We kicked them out.

And, we decided that ministers would be a great disservice to the organization, if they came aboard other than being spiritual advisers; we found out that people have a tendency, if a minister of a particular faith is involved, not to want to be involved themselves. If a minister is part of the leadership, they will not become members, so we decided, "no ministers either." We developed our partnership with the police department, expanding to a few officers in the Seventh District, and the people within the community. And we decided that that was enough for us to go forward and do what we wanted to do.

During this period, while we were putting our strategy together, we stayed off the streets for about a week. Then we came forth again, and this time we had fourteen camcorders, which we bought out by pooling together our own money. We also bought cellular telephones, binoculars and, of course, hats.

Everything that we purchased, we, as a community, purchased ourselves. We did not ask anyone for anything. It was our problem, so we decided we would do it ourselves. We did it.

We came back onto the street with the camcorders, the binoculars, the 35 millimeter cameras and with pads and pencils to write down every license plate tag number that passed through the sector. Nobody could go through without their tag numbers being recorded. We also filmed everything that came through, both automobiles and people on foot. We found there were some interesting tags, and interesting people that came into the drug area to buy. The sons and daughters of some very prominent people in the metropolitan Washington area were

coming through to buy drugs, sons and daughters of bankers, lawyers, police officers, doctors, airplane pilots and everything else. They come through to buy drugs. With the tag number, you can always find the name of the person and the address of the person.

After a few nights on the street, we shut down that automobile traffic through the neighborhood. The word spread quickly about what we were doing, and people who were seeking drugs did not come. When they drove up and saw the orange hats, they decided not to come the extra block where the drugs were located.

And once they leave, we have found that they do not return again. They go to another market.

Knowing this, we decided that we needed to move this kind of activity around the city, to take it elsewhere to other people. Some folks contacted us. We contacted others. And in the course of expanding, now to a total of 52 groups throughout the metropolitan area, we have found that the same people that we have chased out of the drug market in our area also deal in other drug markets.

Now, with the cooperation of the police, we take all the tag numbers from all the groups and put them into a computer. We get a print-out of everybody that passes through these particular areas. From this list, we have found out that a lot of people are carriers of drugs. A lot of them are big time buyers of drugs that buy here to take back to their own communities to sell drugs.

In the course of doing this, we met another group doing similar things in Winchester, Virginia. We went there to visit with them, and while we were there we took tag numbers again and fed them into computer. In many cases, they were the same tag numbers that had been running through the drug markets in Washington, D.C. So we assume that people who are buyers of drugs in these markets are, more than likely, sellers of drugs elsewhere.

All of this information was turned over to the Metropolitan Police Department's Narcotics Squad, and they have used it to find a lot of stolen cars, a lot of wanted fugitives, outstanding bench warrants, and so forth.

As I mentioned earlier, 70 to 75 percent of the members of our organization are female, and some groups are as much as 95 percent female. The group includes blacks, whites, Orientals and Hispanics. Every group is integrated.

We are now in the process of organizing 36 more groups, and we will be getting them onto the street doing the same things we are doing, within the next few months. Like our group, they will patrol the streets every day, seven days a week. Some of our groups have now been out on the street two winters, but every group that has been started is still operating and growing stronger. The Fairlawn Coalition alone consists of approximately 700 people, and the smallest group we have consists of 84 people.

In the whole time that we have been on the street we have not had any violence: No pushing, no shoving matches, no hitting, no shooting, no stone throwing, nothing. We talk with the drug dealers. We joke with them. We treat them like anyone else. But at the same time, they know what we are about, and what we want to do to them. But treat them like humans.

And we always tell the groups that the drug dealer himself, or herself, is secondary to the problem. The problem is the buyers coming in to buy the drugs. They keep the drug dealer going.

We judge our results on the street by the flow of traffic. We do not care how many people stand out on the corner at any given time. If the flow of traffic is not there, then there is no drug dealing. There may be twenty guys standing on the corner with drugs in their pocket, but if there is no automobile or vehicular traffic coming in, and no walking traffic coming in, then we have no drug dealers in that particular community.

When that happens, the guys who deal drugs in that community will leave. They have no choice but to leave. If they cannot sell their drugs, they must go someplace else. What is happening now is that the remaining drug dealing areas are becoming congested with guys who are dealing drugs. So now, they shoot each other because they will not allow another guy into an area to take over their market. "You cannot have my corner," they say. "The only way you can get it is to blow me off it."

Dealers are now are getting to the point where they do not care to go through this any longer, because they know that somebody has to die. Now they are starting to take the market out of Washington. They are going into Virginia or Maryland and setting up there.

We are now getting inquiries from people these areas. Last night, we met with a couple of ladies from the suburbs, and we went there and looked around. A lot of the dealers there are dealers that we used

to see here on the streets of Washington, dealers that we chased out of this town. They went where there is less resistance. They went where the market is.

Kids that used to come out of Maryland and Virginia to buy drugs do not come in any longer, because they have a dealer right there for them to deal with on their own soil. They do not have to come across the bridge any longer.

This is creating a problem for Maryland and Virginia, that's true. But at the same time, it is eliminating the problem here, in Washington. And the citizens here are more concerned with what is happening here than what is happening in Maryland and Virginia. But, at the same time, we are hoping that folks in Maryland and Virginia will mobilize too, to keep it moving. We want to drive the drug market underground, if possible, so that the kids cannot find it. If that happens, pretty soon, the number of people involved in drugs will have to decrease.

Right now, a kid can step outside the door in a lot of areas and step into the market. It is there constantly, every day, seven days a week, and people wonder why kids are involved in it. If it is there, they are going to utilize it. If it is not there, they might not hop on a Metro bus and go across town trying to find it. They might go to the playground, or to the Boy's Club, and utilize the facilities there, instead of utilizing the facilities that the drug dealers have.

In recent weeks, we have added something new. We have encouraged the parents and the grandparents to bring their kids out, to make them come out and stand on the corner with their parents. We put an orange hat on top of their heads and let the guys who are dealing the drugs see these teenagers standing out with their parents, with the neighbors, with the orange hat on their head. We have learned that, once this happens, the dealers will never trust those kids again. If they do not trust them, the kids cannot deal with guys who are dealing drugs again, because they do not want to be around them. They perceive them to be, as they call it, snitches – somebody on the other side, somebody who would turn them in. So that kid is eliminated from the drug market.

We just started this a few weeks ago, but a lot of mothers and grandmothers, have brought their kids out, especially the males. The kids do not want to come out, mothers are so afraid of losing their kids, they force them to come out. This not only works to save the kids, it is also helping to decrease the drug market.

Now, we are in the process mobilizing all the kids in particular neighborhoods. They are going to be called the Pumpkin Heads. This is what they call us on the street, because of the orange hats that we wear. So the name of the youth division will be the Pumpkin Heads. Right now, we have over 12,000 kids that are going to be involved in what we are doing. And the people within the communities are in the process of funding what they are going to do for the kids themselves.

We have not reached, and we have no intention of reaching for, or begging for, funds from anyone. They are our children, so we must spend money on our own kids. We must make sure that our own kids are protected. If, if we can afford to spend money on anything, we can afford to spend money on the youth in the community.

So, having said all of this, I say that if the community is involved, and the community gets together, it works.

One final thing: In the last three to four weeks, the organization has had a lot of political pressure from a lot of candidates within this city, trying to pull the group into one camp or another camp, trying to pull the group apart to utilize for themselves, really.

I can understand it. These are people who are volunteers, who are working volunteers, who spend their time in the streets every night, whether it is cold or rainy or snowing, are people who will work. You have 5,000 hardworking volunteers, and I realize any candidate would love to utilize such a group.

But so far, we have beaten back all comers trying to get the group. Like I tell them all, when they call me, "If you want to see the group, walk the streets, talk to them on the streets, on the street corner, and you can deal with them." But so far, nobody has walked the street, or talked to them. They are still looking for me to bring them all together so they can sit down and talk to them, and I refuse to do so.

Our goal is to make it nonpolitical. We say we will deal with no political party whatsoever in this city. We will stay neutral, and we will deal with everybody. At the same time, we urge everybody to be political individually, to join the process, to be a part of the process. But the organization itself will not be a part of the process. These 5,000 members that we have at this particular time will be working for the community, and for the children, and for everybody else within the community.

Peter Bug Shoe Repair Academy

John Matthews

Our program, Peter Bug Shoe Repair Academy, is a nonprofit shoe repair academy located at 1320 E Street, Southeast, Washington. If you live in Washington, D.C., you can bring your shoes to Peter Bug Shoe Repair Academy to get your shoes repaired at a nonprofit price.

Your money funds the Academy to do three things. We fix all senior citizens' shoes free. We fixed 10,000 senior citizens' shoes last year, including pick up and delivery. Your money also buys supplies. Your money also hires young people.

Our organization, is called the Peter Bug Shoe Repair Academy, but it should be called the Peter Bug Youth Entrepreneurship Academy. For example, we have in our Academy something called one penny stocks, and we teach young children how to buy and sell stock.

We also have a T-shirt program, and we train young people not just to make T-shirts, because anybody can make T-shirts. Anybody can do arts and crafts. Anybody can dunk the basketball. Everybody can hit it, and everybody can run it. But can you sell it? Can you sell that basketball? Can you make those tennis shoes? Can you fix that basket?

That is what we teach in the Peter Bug Shoe Repair Academy. I teach young people how to make money. We teach young people the art of running a business. Not just fixing shoes. Not just fixing T-shirts, but how to run a business. Where to go to do the marketing. Where to go to the guy who sells the supplies. How to buy. How to take inventory. And, the most important thing: the across-the-counter relationship with the customer.

It is easy to hold conferences and talk about what we are going to do, but have we taken the time, that one minute, to talk to a child. Imagine that everyone took one minute a day, then told their neighbor to take one minute, that is two minutes. That is two children. If you have fifteen friends, how many times per year is that that we can sit down and talk to young people?

Young people only want love. You cannot lock them up in a cage like a dog, because they are going to break out. You cannot keep chasing them off the street. I went to a playground yesterday at 13th and E Street Southeast, right near my shoe repair shop. They have a sign on the playground, "No loitering." Now, if kids cannot loiter on the playground, where can they loiter?

The Peter Bug Shoe Repair Academy buys the right kind of loitering, the right kind of hanging out, the right kind of back porch counselling. Police get kids off the street. They run them out of town into Virginia. They stop all the dope. But have we thought about where they are going to get money to eat?

The Peter Bug Youth Entrepreneurship Program is a program that we offer to young people on how to make money. It is not about making money just to make it, because the welfare programs give people money. If we do not show people how to manage money, they are not going to buy anything but doughnuts and cupcakes, and then they eat all that up today, and they have no food left for the 31st of the month.

We talk about providing better education. But one thing young people can do today is add. Drug dealers might have $1 million, and not one penny is missing, and if any of it is missing, you see the results of it. They kill somebody on the corner. So they know how to count.

Sometimes they do not know how to read, so what we do at the Peter Bug Shoe Repair Academy is we give them an opportunity to read. I do not care if it takes you all year. You are going to read.

What Peter Bug Shoe Repair Academy offers is, most importantly, love. We try to listen to young people. We try to give them another way of making money. We try to give them hope, and that is important, but we also give them reality.

If you want this drug problem to stop, you have to put two things back into children. You have to give your time. You have to cut that TV off and give something back to the child. Children are only mocking what they see. If you do not clean up, they are not going to clean up.

Secondly, you have to give love. If you do not have any children, knock on your neighbor's door, and say, "Excuse me. I want to come in for five minutes and hug your children, because I want to let them know that there is love in the community."

The Role of the Church in Fighting Drug Abuse

Reverend Richard Dalton

As James Foreman points out in his paper, I was involved in working with him to develop the Fairlawn Coalition, and one of my memories of that period is the lack of any kind of systematic plan of action by the church to do something about the drug problem. When I would go to meetings, Mr. Foreman and others would ask me, "Reverend Dalton, where are the ministers?" I said, "I don't know where they are."

The church historically, particularly in the African-American community, has always been the cornerstone of social change. The NAACP, Southern Christian Leadership Conference (SCLC) and Dr. King all had their roots in the African-American church. So it stands to reason in this time of crisis that we need the participation of the churches, particularly in the black community.

Now I am working with the SCLC to develop an anti-drug program there. One of the reasons that SCLC is so involved in the anti-drug effort is because of the disproportionate impact drugs have in the black community in terms of drug-related murder and violence.

We have developed a practical plan of action for the church to get involved in the war on drugs. It is called The Wings of Hope, and it is a church-based anti-drug initiative with three phases. In phase one, we identify churches in drug-infested areas, and ask them to develop, within their congregation, a drug prevention committee. Once they develop a drug prevention committee, SCLC will coordinate training in substance abuse, chemical addiction and AIDS education from different treatment centers throughout the city to train that drug prevention committee over a four-to-six month period.

The second phase is to ask churches to adopt families in drug-infested areas.

The third phase is to ask churches to help develop anti-drug coalitions, like the Fairlawn Coalition, to help them provide leadership and develop the kind of initiatives that James Foreman talks about.

We consider phase two, the family adoption phase, the most important. For example, in Atlanta, we have adopted over twenty families in public housing units, large proportion of which are single-parent households. These mothers were either teenagers when they had the children, or they are teenagers now, so we asked the church to become an extended family, through the adoption process, and help with the development of parenting skills. We ask the churches to encourage those mothers who have dropped out of school to go back to school to get their GED. Opportunities Industrialization Centers sits on the board of our anti-drug task force to coordinate job training for those mothers. Our effort is to empower the family rather than trying to be a caretaker of the family.

Also in phase two, if one of the members of the family is addicted to drugs, those churches that have received training on drug counselling know how to refer people to treatment programs and how to support and care for the family with respect to that problem.

We believe that this effort will cause three things to happen. First, there will be a reduction in the demand for drugs in areas where all the churches providing training for their congregations, adopting families and doing community organizing. Second, there will be more family cohesiveness. The family unit in those particular areas will be empowered because the church becomes the extended family. Third, because of these first two effects, there there will be less crime.

The program is now operating in Chicago, Miami, Dayton, Atlanta, and Cleveland. William Bennett recently went to Cleveland to see the Winds of Hope Anti-Drug program in operation, and selected two of the participants in the program to join the twenty people that he honored throughout the country.

The drug problem problem that did not happen overnight. It is going to take a commitment from the church and from community groups like the Fairlawn Coalition to help clean up these communities. It is difficult for ministers, sometimes, to work together without having turf battles. But there seems to be more interest in churches coming together, ministers coming together, to work together as a unit, and to provide the kind of care and support that needs to take place in these communities to take care of our youth and to take care of the families that are in these communities.

PART VI

THE ROAD AHEAD

Responding to New Challenges in the War on Drugs

Hon. William J. Bennett

Last summer, Secretary Louis Sullivan and I released the findings of the 1988 National Household Survey on Drug Abuse. As I described the results then, we are fighting two wars. The first, more manageable front against casual drug use has turned in our favor. Overall, there are fewer Americans using drugs than five years ago. But we have a second front. It is against chronic, addictive drug use – cocaine use in particular – and we are not yet winning on that front. For every indication we have that overall drug use is declining, we have another reminder that chronic, addictive drug use is declining, we have another reminder that chronic, addictive drug use remains a severe and stubborn problem. There is some evidence that things are not getting worse on the second front, but it will still be some time before things there will be better and seem better.

In a way, this stubborn front is the part of the problem we are most familiar with. The drug problem that we read about in our newspapers each day and see on TV at night is usually about habitual cocaine use and the crime that often accompanies it. On this front we see the hard-core addicts. We stare at and pity the cocaine babies. We are shocked by the crack houses. The drive-by shootings. The decaying neighborhoods. And although our data are not what they should be, it seems to most demographers that this part of the problem is concentrating increasingly in our poor, black, and Hispanic inner-city neighborhoods.

Having said that, let me hasten to add that this is by no means a problem of *every* inner-city neighborhood. Again, by a long shot, most black and Hispanic citizens are innocent of drugs, either as users or dealers. They are most often the victims, not the perpetrators, of drug crime. Most inner-city residents are people who, despite their poverty,

despite their often run-down housing, and despite the dire predictions of the culture-of-poverty theorists, confront and resist drug use every day. They are America's new invisible men and women. We rarely hear about them. We rarely see them on TV. But they are there. They retain their dignity and pride by keeping their children away from drugs, obeying the law, and by opposing the drug dealers in their midst.

It is at the second front of the problem that many of these good citizens live, and life there can be very tough. The problem is tough not for any abstract, philosophical reason; not because we can't comprehend the culture of inner-city life; and not because we don't understand it. It is tough because of the facts on the ground, and the very tough nature of those facts. Life in some of these drug-torn neighborhoods is characterized chiefly by its murder and addiction rates. Here drug kingpins may be heroes to the young, and the meanest thugs can rule the streets. Open air drug markets are adjacent to elementary schools, crack vials are strewn across parking lots, and in some schools, students must walk through metal detectors to check for weapons.

I have been to 41 American cities where there are drug problems and it is no exaggeration to say that in some of these places, drugs have made life very much as Hobbes imagined it to be in the state of nature: solitary, poor, nasty, brutish, and short.

Now given these facts – facts not open to serious dispute – I confess that I still find it remarkable that there remains any debate over what our response should be to this specter. The position that I have taken all along is that the rehabilitation of a community cannot begin until some degree of fundamental order and basic civility has been established. Treatment and education stand little chance of succeeding if they must compete in a neighborhood where drugs and drug dealers flourish on every corner. Most people who use drugs cannot be made whole or made well in such an environment.

Yet some people think they know different. One critic insists that "until the root causes of drug abuse are addressed – the lack of education, housing, employment, health care, family, and above all poverty – the scourge of drugs will continue to expand." He and many others argue, essentially, that the real task of drug policy in these communities is not to create safety and order, but to rid society of poverty, unemployment, racism, illiteracy, disease. I say we need to get at these things too, but we must immediately, and directly, and with all deliberate speed, go after the drug problem. The larger conditions do

exist, of course, and no one denies that they are important factors in *locating* chronic drug use. But I have grave doubts that we can *explain* the drug problem in our cities merely by pointing to surrounding social conditions.

Now let's agree on some things: unemployment makes people poor. Poverty deprives them of certain material goods. Prejudice keeps them excluded. Broken homes or non-existent families make children vulnerable. Bad schools do the same. All these things may indeed make people more likely to succumb to drugs; they sap the spirit and weaken the will. They are conditions that present us, all-together, with a kind of weakened immune system. But drugs are the invading virus. And you must attack the virus while you are pondering how to strengthen the immune system. Drugs are not merely a symptom, they are a cause, an efficacious and sometimes deadly one. They degrade human character. They sear the mind and they numb the soul. And that is why we oppose them.

Drugs can make other serious problems seem modest. As John Jacob, president of the Urban League, has observed: "Drugs have destroyed more families than poverty ever did." I think he's right. Drugs can turn good citizens into victims. They can turn otherwise solid citizens into addicts, and even into criminals. That's why good citizens in bad neighborhoods need our help – active and aggressive help.

When drugs penetrate a neighborhood, all other efforts to improve the condition of the people who live there are weakened. Schools can't function when gang members roam or rule the halls. The local economy can't work when store owners, tired of risking their lives, move their businesses elsewhere. Young people don't bother looking for honest work when it seems as if only crime pays. Streets, parks, and recreational areas become places to purchase drugs, consume them, and wage gang war on a daily basis.

To save these communities, the legitimate forces for good – law enforcement officials, private citizens together, all the agents of the rule of law and civility – must assert themselves. Measures of enabling toughness are called for because, as Flannery O'Connor wrote: "You have to push as hard as the age that pushes against you." Only here, with drugs, you must push harder.

That means that in our inner-city quasi-states of nature the good guys must confront the bad guys, and they must win. They must do so responsibly, lawfully, and constitutionally. But they *must* also do so

decisively. This is true and it is common sense. And I say it because the people who live in neighborhoods that most of us here would be too scared to walk through say it too. Last week, a number of courageous local heroes – from Albuquerque, New York, Houston, Oakland, and other cities – came to Washington to have lunch at the White House and exchange stories about their experiences. Some of them organize neighborhood patrols; others bring anti-drug messages to schools or youth groups. But all of them know this to be true: where they live, as elsewhere, order must prevail over chaos. Similar men and women live in the towns and cities where your papers are published. Ask them.

When you meet people who have seen the drug epidemic up close, they'll tell you that there are two arguments they hate hearing. The first is that we should legalize drugs. The second is that their neighborhood doesn't need more cops. The fact is that they need more cops and they want them. If you disagree with me or with them, then let me suggest that you go see for yourself.

In the neighborhoods where they live, law enforcement is not a political option or a policy question; it's a moral imperative. The drug trade has succeeded in many places in eroding the basic sense of security that is a precondition of life, liberty, happiness, and so much else. So while others debate the fine points of root causes, and deride the role of basic law enforcement, the residents of poor neighborhoods are busy marching on crack houses, putting locks on their doors, and chasing dealers out of apartment courtyards. Sometimes, in the absence of enough police, they themselves help patrol the streets.

I think if we fail to see this part of the drug war, this second front, as *first* a question of restoring an essential level of security to citizens, then we risk ignoring the most pressing concern of the people who live there, the people who everyone involved in the debate say they want help. If we fail to act here, their lives will go on, but they will increasingly be lives shaped by drugs and the street culture drugs have produced. And on such streets, as we all know, drugs themselves will soon become a root cause of one more generation's misery.

Finally, let me point to the educational implications of what we do or fail to do. If we teach that crime is wrong and that, in the end, crime doesn't pay, we should be ready to back up those sentiments with action. Not for the sake of seeming tough, being tough, or acting tough, but for the sake of acting compassionately toward our children. What I mean is so obvious it seems to have been forgotten, but as Orwell said,

sometimes our most important responsibility is a restatement of the obvious. Here's the obvious: there are two thing children need more than anything else; they need love and they need order. And if you love children, the first thing you do for them is to secure their safety. I ask you: why might some people who work to provide these things for their own children deprecate the value of these things to the children of others?

In my neighborhood, middle- to upper-class Chevy Chase, Maryland, if we see someone selling drugs on the street, there is no debate about what we do. We call 911. We do not convene a seminar on root causes. We expect action, and if we don't get it we raise hell. I think that is a natural, civilized, and appropriate reaction. And I don't believe for a moment that a single parent in Southeast Washington should behave any differently. Equality is the oldest promise of America. Parents – all law-abiding citizens – have an equal right to expect security regardless of where they live.

We have been examining the problem of poverty for decades. Fine. Let it go on. Let it go on smarter. But today the primary need is not to *study* residents of poor neighborhoods, but to *help* them. How? By doing unto them what we do for ourselves. I'm asking that we start treating these drug benighted neighborhoods as if we lived there, not as if they were some laboratory for social policy. If we do, we can make things better. I think we can do so soon. And I think we have to, soon.

Participants

Thomas J. Agnos is Sheriff of Maricopa County, Arizona.

William J. Bennett, at the time of the conference, was Director of the Office of National Drug Control Policy.

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Robert L. DuPont is Vice President of Bensinger, DuPont & Associates, a national consulting firm specializing in the prevention of drug and alcohol problems in the workplace, and former Director of the National Institute of Drug Abuse.

Jeffrey A. Eisenach is a Visiting Fellow at The Heritage Foundation.

James Foreman is a co-founder of the Fairlawn Coalition, comprised of groups of Washington, D.C. citizens who are taking their communities back from the drug dealers.

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John "Peter Bug" Matthews is founder of Peter Bug's Shoe Academy, a Washington, D.C., non-profit organization that teaches entrepreneurial skills to youngsters.

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THE HERITAGE LECTURES

Winning the Drug War

Tremendous progress has been made in reducing illegal drug use in the United States. Conservative policies, including a renewed emphasis on law enforcement, can take some credit for that progress. Yet, drugs remain a major problem. The nature of the drug problem is changing, and new approaches are needed.

There is no single, easy solution to illegal drug use. Over the course of the two decades that America has been fighting the current drug epidemic, thousands of different approaches have been taken. Some have succeeded, others have not. Some solutions have worked for a time but, as the problem itself has changed, the old solutions have outlived their usefulness.

To take stock of America's war on drugs, The Heritage Foundation assembled a panel of distinguished soldiers from the front lines. Their discussions, reprinted in this volume, highlight the approaches that are working, identify the areas in which progress still is needed, and explore aggressive and innovative approaches to deal with the parts of the problem that so far have defied solution.

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