BREAKING THE CHAINS: PEOPLE OF COLOR AND THE WAR ON DRUGS

CONFERENCE

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FACT SHEETS

BREAKING THE CHAINS

People of Color and the War on Drugs

September 26 – 28, 2002
Hyatt Regency Los Angeles at Macy's Plaza,
711 South Hope Street, Los Angeles, CA
www.breakingthechains.info
888-361-MEET (6338)

HOW DID WE GET INTO THIS MESS?
RACE, CLASS AND THE HISTORY OF U.S. DRUG POLICY

Was there a war on drugs a hundred years ago?

No. A century ago, opiates, cocaine and cannabis were freely available and used both medicinally and recreationally by people throughout the United States. Scores of patent medicines, elixirs and liquid concoctions contained substantial amounts of opium or cocaine.

How was problematic drug use dealt with at that time?

The outstanding feature of early 20th century opiate and cocaine addiction is that the vast majority of addicts were from the middle and upper classes. The peak of opiate addiction in the United States occurred around 1900, when the number probably was close to 250,000 in a population of 76 million, a rate so far never equaled or exceeded in the United States. Nonetheless, the prevailing attitude was that drug addiction was a health problem, best treated by physicians and pharmacists. Because so many people had become addicted unwittingly through their use of patent medicines and other products containing addictive drugs, Congress passed the first Food & Drug Safety Act in 1906 requiring that products list their contents.

When and why did these policies change?

Public attitudes about drug use began to change as perceptions about drug users shifted. In 1909 the U.S. international "war on drugs" began when California prohibited the importation of opium.

Chinese immigrants. Though only a small fraction of American drug users were Chinese, opposition to opium smoking grew as it was increasingly linked to Chinese immigrants in the western United States. Strong anti-Chinese sentiment, exacerbated by a growing fear of competitive cheap labor, led to the Chinese Exclusion Act of 1882, which forbade further immigration. Fears that "respectable" white women were being seduced into a life of prostitution and debauchery in opium dens were inflamed by sensationalized reports. In 1902, the Committee on the Acquirement of the Drug Habit of the American Pharmaceutical Association declared: "If the 'Chinaman' cannot get along without his 'dope,' we can get along without him."

African Americans. In 1910 Dr. Hamilton Wright, considered by some the father of U.S. anti-narcotics laws, reported that U.S. contractors were giving cocaine to their [black] employees to get more work out of them. A few years later, stories began to proliferate about "cocaine-crazed Negroes" in the South who had run amok. The *New York Times* published a story on February 11, 1914 that alleged "most of the attacks upon white women of the South are the direct result of the 'cocaine-crazed' Negro brain." The story asserted that "Negro cocaine fiends are now a known Southern menace." Some southern police departments switched to .38 caliber revolvers because they thought cocaine made blacks impervious to .32 caliber bullets.

Mexicans and Chicanos. During the Great Depression, the U.S. Congress passed the 1937 Marijuana Tax Act, again using racism as a key selling point. The same Mexicans who were vying with out-of-work Americans for the few agricultural jobs available, it was said, engaged in cannabis-induced violence against white Americans.

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From Crisis to Power: Breaking the Chains of Addiction

What is drug addiction?

Drug addiction refers to a pattern of consumption marked by the compulsive taking of a drug, the need for increasing amounts of the drug over time to maintain the same effect (*tolerance*), and the appearance of symptoms when the drug is stopped that disappear when it is taken (*withdrawal*). In short, addiction describes compulsive behavior and the mental and physical reactions that follow both when the behavior is performed and when it is not.

What are the different types of drug treatment and how do they vary in method and effectiveness?

There are various types of treatment that address drug abuse and addiction. Approaches may include components such as detoxification, assessment, outpatient services, inpatient services (short term and/or long term) and follow-up services. It is important for individuals to understand what their program's expectations are regarding ongoing drug use while accessing services. Some programs have an abstinence-based philosophy while others have a harm-reduction approach. Abstinence-based programs define success as the ability to remain drug free, while harm reduction-based programs will work with individuals "where they are at" and define success by the individuals' ability to reduce the harms their drug use causes to themselves, their loved ones and society. Harm reduction-oriented treatment emphasizes maximizing health and safety for users and non-users alike.

Studies demonstrate that the most important component of treatment success is an in-depth clinical assessment of the individual's health, social support and motivation; the assessment allows for the best match to appropriate treatment. The length of program services and accessibility of services also have a high correlation to success rates.[1]

What factors influence access to and duration of drug treatment?

Poverty, class, race, social isolation, past trauma, sex-based discrimination and other social inequalities all affect access to treatment and length of treatment services.

According to official government estimates, 82 percent of the 6.1 million Americans in need of substance-abuse treatment do not receive it in spite of its proven effectiveness when compared with criminal justice approaches. The 2002 federal drug war budget is $18.8 billion, slated to increase to $19.2 billion in 2003. Of this, just $3.8 billion is targeted for treatment, while nearly two-thirds is spent on law enforcement.[2]

Lack of adequate health insurance and lack of payment parity for treatment services affect access to treatment. An individual may be ready to enter a treatment program and find that he/she has insufficient insurance coverage, if insurance at all. When health insurance does cover treatment, many times the waiting list for treatment programs limits access and can further discourage those willing to take the first step to addressing their addiction.

critical to note that, **according to six government reports, needle exchanges and harm reduction measures do NOT lead to more people using drugs.**[10] Every major scientific body to study the issue, including the AIDS advisory commissions of both Presidents Bush Sr. and Clinton, formally endorsed the efficacy of needle exchange and called for its expansion.[11]

Hepatitis C. Studies also show that the occurrence of Hepatitis C is on the rise in communities of color. The need for more information on how to prevent the spread of this disease is being seen as a priority for many health officials and community members.

Family Health Concerns. Women with children are suffering as well. The transmission of disease might be better prevented if the fear of criminal justice involvement could be averted. Access to appropriate prenatal care has been shown to be a factor in the delivery of healthy babies. A mother who might be using drugs and/or in treatment can be punished and her child custody threatened if she accesses health services. A woman who decides to take the risk and get care may not share her complete history, possibly affecting the treatment services she receives. Notably, studies show that many women find motivation to address their addictions because of a pregnancy and want an opportunity to create a healthier and safer environment for their children.

Health concerns are not limited to HIV, AIDS and Hepatitis C. As a result of poverty, lack of educational opportunities and felony records due to drug use, communities of color find themselves struggling with health concerns that might be otherwise avoidable or more effectively addressed.

How have overdose rates been affected by the war on drugs?

Between 1990 and 1996, drug related deaths increased from 5,628 to 9,310, a 65 percent jump. During the same period, cocaine and heroin-related emergency room visits nearly doubled to more than 210,000.[12]

Drug overdose deaths are an overlooked epidemic in the United States. In the Orlando, Fla., area, for example, heroin-related deaths increased more than 10 times in one year (1994 to 1995).[13] In Portland, Ore., New York City, San Diego, San Francisco and Seattle, young men ages 20 to 54 are more likely to die by drug overdose than by car accident.[14] Despite these alarming statistics, the federal government does not accurately monitor overdose death rates. Only 20 states have accurate information that dates back to 1990, and there are no federal programs or funds directed to overdose prevention.[15]

There have been successful programs that have improved the health of people who use heroin and prevented overdoses until users can effectively address their addiction. Methadone maintenance treatment (MMT) is the most effective and proven method of treating heroin addiction and reducing the death, disease, crime and suffering associated with it. Yet methadone remains one of the most regulated, restricted and underavailable medications in the United States.[16] With few exceptions, methadone is distributed only at specialized methadone centers. Doctors cannot prescribe it, which makes it unavailable to many patients who might benefit from it.

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[1] Harm Reduction Coalition Web Site, http://www.harmreduction.org.
[2] Office of National Drug Control Policy. *National Drug Control Strategy: FY 2003 Budget Summary.*
[3] Singh GK, et al. *Advance Report of Final Mortality Statistics, 1994.* 45 VITAL STATISTICS REPORT 31-33. Centers for Disease Control. (Sept. 1996 Supplement).
[4] Day D. *Health Emergency 1999: The Spread of Drug-Related AIDS and other Deadly Diseases Among African Americans and Latinos*, The Dogwood Center (1998), p. i.
[5] Ibid.
[6] Ibid.
[7] Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report,* 11(No2); 1999.
[8] Lurie P, Drucker E. "An Opportunity Lost: HIV Infections Associated with Lack of a Needle Exchange Programme in the USA." *Lancet* 1997; 349:604-608.

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Crime & Punishment: The U.S. Criminal Justice System and Punitive Drug Laws

What political factors contributed to the development of a criminal justice-based drug policy?

Domestically, U.S. drug policy is fueled by historical bias against people of color used to justify their disproportionate presence in the penal system. Despite the fact that drug use is more or less consistent across racial lines, many punitive drug laws are based in part on the belief that communities of color commonly use certain substances. Such was the case with opium and Chinese immigrants, cannabis and Mexicans, and cocaine and African Americans.

What is the relationship between racial profiling and drug law enforcement?

Enforcement of the drug laws is the primary motivating force behind racial profiling activity. When cars are stopped and searched at random – the randomization that creates an opportunity for race-based decision making – officers are rarely looking for evidence of crimes such as shoplifting, burglary or murder. Instead, they are searching for drugs or other evidence of drug-related activity.

A 1996 study of traffic stops along Interstate 95 in Maryland showed that blacks constituted 72.9 percent of all drivers stopped and searched by the state police, though they made up only 17.5 percent of the total drivers, and were no more likely than their white counterparts to be violating the law. The same study demonstrated that while people of color (African American, Latino, Asian, other) constituted only 21 percent of the total traffic offenses on the road, they constituted 80 percent of the stops made. Lawsuits alleging racial profiling of motorists have been filed in Maryland, New Jersey, Illinois, Indiana, Pennsylvania, Florida and other states.[i]

There is a self-perpetuating, cyclical quality to the treatment of blacks and Latinos in the U.S. criminal justice system. Much of the discrimination visited upon these groups stems from the perceptions of criminal justice decision makers that (1) most drug crimes are committed by people of color and (2) most people of color commit drug crimes. Although empirically false, these perceptions contribute to a disproportionate share of law enforcement attention directed at people of color, which in turn leads to more arrests of blacks and Latinos. Street sweeps, buy-and-bust operations and other police activities exacerbate the problem by targeting people engaging in street-level retail drug transactions in low-income communities (as opposed to the less visible drug activity prevalent in more affluent communities). Disproportionate arrests fuel prosecutorial and judicial decisions that result in racial disparities in incarceration. The accumulated effect is to create a prison population in which blacks and Latinos increasingly predominate, which in turn reinforces the misperceptions that justify racial profiling and punitive drug policies.

What impact have mandatory minimum drug sentencing and conspiracy provisions had on the criminal justice system?

During the 1970s and 1980s, sentences for drug offenses increased dramatically for three reasons. First, Congress and many state legislatures passed mandatory minimum sentencing and "three strikes" or "habitual offender" laws that require judges to hand out fixed sentences to people convicted of certain crimes. Second, "truth in sentencing" laws and other laws abolishing parole release systems were enacted. Third, the application of conspiracy provisions for drug offenses has made it possible to convict and sentence any individual as a major

Crime & Punishment

Almost 41.4 million African American males, or 14 percent of the adult black male population, are currently unable to vote as a result of felony convictions. Black men represent more than 36 percent of the total disenfranchised male population in the United States although they make up less than 15 percent of American males.[vi] In 1995, one in three black men between the ages of 23 and 29 was either in jail, in prison or on probation or parole,[vii] most of them therefore unable to vote.

Prisoners are counted by the national census as residents of the towns in which they are imprisoned, leaving their hometowns – often urban communities of color – with diminished political power and government funding. Since voting representation and the distribution of government resources are determined by population, drug law convicts of color bring a transfer of public funds and electoral influence from their home communities, which are generally urban and often poor, to the mostly rural towns in which they are imprisoned.[viii]

The effects of these levels of discrepancy are huge, resulting in decreased trust of the criminal-justice system within communities of color. When someone is removed from their community, there are ramifications both for that individual and for the community as a whole. There are fewer people there to work, to raise children, to buy goods for sale, to vote and to be part of community and religious institutions.

How else have families and communities of color been impacted by drug law enforcement?

As more and more people of color face incarceration due to drug charges, the collateral effects on their families and communities are numerous. Increasingly, children are raised by either one parent or by grandparents or other extended family members because of the incarceration of a custodial parent. If they have no family members available to care for them, these children are integrated into a foster care system that is overburdened, under-supervised and expensive. Studies show that children who are separated from their families do not perform as well in school, have greater physical and mental health problems and are at higher risk for criminal justice involvement. Finally, when parents return to their communities, their drug convictions often make it difficult to find work or qualify for certain benefits, affecting their ability to reunite with and care for their children. Instead of facilitating healthier lifestyles, drug law enforcement perpetuates disintegration of family and community structures and creates cycles of economic and community struggle that many find difficult, if not impossible, to overcome.

What would alternative approaches to current criminal justice-focused drug policy look like?

Affluent, predominantly white suburban communities have long recognized that the drug war need not be fought only on the incarceration front. Alternatives such as drug treatment and education are mainstays of white, middle-class efforts to reduce drug abuse in their neighborhoods. A strategy centered on such demand reduction efforts makes sense: The Rand Corp. has estimated that investing an additional $1 million in drug treatment programs would reduce serious crime by 15 times more than enacting mandatory sentences for drug offenders.[ix] An effective, alternative approach to drugs would focus on the actual health and safety of communities and families and provide an appropriate array of services and resources so that each individual has the opportunity to realize his or her full potential.

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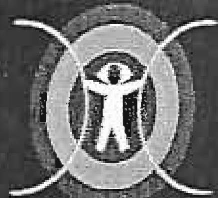
[i] Harris, David. *Driving While Black: Racial Profiling on our Nation's Highways.* ACLU Special Report, June 1999. http://www.aclu.org/profiling/report/.



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The Drug War Across Borders: US Drug Policy and Latin America

How is Latin America affected by the U.S. war on drugs?

The war on drugs is fought on two fronts: at home and abroad. On the domestic front, policymakers attempt to reduce American drug use through the criminal justice system by coercing and punishing people who use or sell drugs. On the international front, the U.S. sponsors military and police efforts to combat the production and export of illegal drugs from other countries. These strategies are known, respectively, as "demand reduction" and "supply reduction."

Latin America, which produces nearly all of the heroin and cocaine consumed in the United States, is the principal target of U.S. international drug war efforts. Over the past 15 years, the United States has spent more than $25 billion on the two main supply reduction methods: interdiction and crop eradication. Interdiction refers to attempts to seize drugs at the border or while they are en route to the United States. Eradication refers to attempts to eliminate drug crops – the plants used to make cocaine and heroin, for example – while they are being grown. The most controversial method of eradication, employed principally in Colombia, is "aerial fumigation" – the spraying of poison from military-escorted airplanes onto farms that grow coca (the plant from which cocaine is derived) or opium poppies (from which heroin is made).

Does source-country "supply reduction" work?

No. The drug war has consistently failed to reduce the supply of drugs from Latin America. Despite decades of aggressive policies in Latin America and at the U.S. borders, illegal drugs such as heroin and cocaine remain cheap, pure and readily available on U.S. streets.

Though eradication may temporarily reduce drug crop production in one particular area, it almost always leads to increased production in other countries and areas. This is known as the "balloon effect"; pushing down production in one place simply pushes it up in another. Undiminished demand for drugs, combined with the nearly inexhaustible supply of cultivatable land and extremely high levels of poverty found throughout Latin America assure that new producers will arise to fill the void. For instance, in the mid-1990s, U.S. efforts led to a 66 percent reduction of coca cultivation in Peru and a 53 percent reduction in Bolivia while cultivation doubled in Colombia. The net amount of cocaine exported by the region as a whole was not significantly changed.

Does interdiction at the U.S. borders work?

Interdiction schemes largely fail. The sheer scale of the U.S. borders and the constantly improving tactics of profit-driven drug smugglers make illegal drugs a very tiny needle in a very large haystack. It is a nearly hopeless task to prevent easily concealable substances such as heroin and cocaine from coming in through more than 12,000 miles of shoreline, 300 ports of entry and more than 7,500 miles of border with Mexico and Canada. By optimistic estimates, interdiction efforts only seize 10 to 15 percent of the heroin and 30 percent of the cocaine coming into the United States.

The Drug War Across Borders

Aside from the increasing number of border-crossing workers being detained, the crossing itself has become more dangerous. Many suffer from heat stroke and heat exhaustion or even die of dehydration caused by staying in overheated trucks for too long without water or from having to cross the border in areas without cover because they are not under as heavy surveillance as others. Many people who need work have taken to crossing the border by vehicle. Aside from the financial cost of such transport – often resulting in substantial debt – people are increasingly required to carry drugs as part of the cost of their passage. Often described as "mules," workers run the risk of criminal and/or Immigration & Naturalization Service sanctions, as well as potential health ramifications when the drugs are transported within the body.

Where should the United States focus its drug control efforts?

U.S. domestic drug-related problems are exactly that: U.S. problems. U.S. drug policies should focus on developing effective approaches to reducing the demand for and abuse of drugs at home through effective drug treatment and education strategies, not failed and harmful interventions at the border and abroad. The long-term goal of drug policy reform is the adoption of a hemispheric drug control philosophy based on public health and regulation rather than prohibition and punishment. Such a philosophy would abandon the failed supply reduction/demand reduction strategies of today, acknowledging that drugs and drug abuse have persisted and will persist, both in the United States and in Latin America, for the foreseeable future. It would replace the relationship of antagonism and blame between North and South with one of genuinely productive cooperation. And it would be based on the same principles reformers advocate domestically – a commitment to reduce the harms of both drug use and drug policies as effectively as possible while maintaining a strong commitment to individual and national sovereignty.

Latin Americans should be supported in their efforts to reduce the harms caused in their countries by drug prohibition and drug abuse – not punished by U.S. drug warriors looking for someone to blame. They must have all options, including decriminalization or taxation and regulation of the drug trade, open to debate. A short-term goal of drug policy reform in Latin America is to broaden and amplify such a debate among the press, public and policymakers.

Sources and Suggested Reading:

Bolivia Under Pressure: Human Rights Violations and Coca Eradication. Human Rights Watch/Americas, vol. 8, no. 4 (D), May 1996, (17k), http://www.hrw.org/hrw/summaries/s.bolivia965.html.

Gootenberg, Paul. *Cocaine: Global Histories*. Routledge, 1999.

Gray, Mike. *Drug Crazy: How We Got Into This Mess & How We Can Get Out*. Random House, 1998.

Joyce, Elizabeth; Malamud, Carlos. University of London, Institute of Latin American Studies. *Latin America and the Multinational Drug Trade*. London: Macmillan. 1998.

Rabasa, Angel; Chalk, Peter. *Colombian Labyrinth: The Synergy of Drugs and Insurgency and Its Implications for Regional Stability*. Rand Corp., 2001. http://www.lindesmith.org/cites_sources/0833029940_frame.html.

The Transnational Institute, The Bolivian Documentation and Information Center, and Inforpress Centroamericana Guatemala. *Democracy, Human Rights, and Militarism in the War on Drugs in Latin America*. April 1997. http://www.tni.org/drugs/folder1/contents.html.

United Nations Office for Drug Control and Crime Prevention. *Global Illicit Drug Trends 2002*. June 2002. http://www.odccp.org/odccp/global_illicit_drug_trends.html.