The Drug Abuse Industry and the "Minority" Communities: Time for Change,

by Frank Espada

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From Handbook on Drug Abuse, Robert I. Dupont, M.D., et. al., 1979, pages 287 to 300.

Editors note to the section titled The Ethnic Minority Response, page 256: As many of the chapters of this handbook point out, the drug problem is largely a problem of minority groups, and a chapter on drug use among minorities could legitimately include almost all aspects of the problem. Faced with the impossibility of covering this within the limits of a short chapter, Espada has chosen to focus on one point, the need he perceives for minority group representation at the policymaking level.

BACKGROUND

This paper will attempt to place the issue of "minorities" and drug abuse in a clearer perspective than has heretofore been available.

We will lay out, in a cause-and-effect manner, the reasons why minorities can make a strong case for a total revamping of the drug-abuse establishment—from national policy formulation to research goals and objectives to treatment and prevention strategies and approaches.

We believe the facts support the following set of assumptions:

• That hard-opiate abuse has been, and continues to be, primarily a minority youth problem.

• That drug laws have been traditionally repressive, racist in nature, and are applied primarily as another social-control mechanism aimed at minority groups.

• That, in spite of the above, the field has been traditionally controlled by the dominant society, applying the medical model to what is essentially a social problem.

• That, because of the above, the Federal and State response (policies, priorities) has been inadequate to meet the needs of those most affected

by the problem.

• And that, because of all of the above, minorities have organized along ethnic and racial lines to try to impact on National and State policies.

• Finally, some conclusions and recommendations, as well as some implications affecting research, treatment, and prevention efforts, are offered.

HARD OPIATE ABUSE AS A "MINORITY" PROBLEM •

The quotes around the word "minority" simply indicate a misnomer. For in this field we can easily show, using CODAP and DAWN data, that minorities constitute a disproportionate majority of hard-opiate abusers.

CODAP data for the first half of 1976, as well as for all of 1975, indicate that somewhat more than half of the reported drug abusers came from minority groups. Further, and more to the point, 63 percent of all heroin abusers were from minority communities. This situation is nothing new. Essentially the same has held true for at least 30 years, since large numbers of minority youth began serious opiate abuse in the late forties (Espada 1977).

Further, this is supported, after some adjustments, by both the CODAP and DAWN systems, which yield identical results with different data sources. The third major national data system— Texas Christian University's Institute of Behavioral Research— indicates that heroin-user admissions to drug treatment in 1969-73 were 74 percent nonwhite. However, and more importantly, it is clear to this writer that there is a sharply qualitative difference in opiate abuse in the minority communities. Opiate abuse affecting one-half of 1 percent of the white adult male population may be (and often is) viewed as a harassment, a loss, a significant form of deviancy. However when a similar problem affects, say 5 percent of the young adult males in the minority communities, another situation develops. Involvement with or addiction to opiates then becomes a significant way of life, pervading a community; a competing and often destructive lifestyle. It becomes a condition the community lives with at all times rather than an event affecting others or galvanizing people into action.

Further, the drug-use situation is confused and exacerbated by the cultural context in which drugs are meshed. In recent years two factors seem to have been especially important in the perceived increase in drug abuse in minority

communities: First, unemployment, especially among older teenagers and young adults, has soared in these areas and shows no signs of abating. In the South Bronx, for example, unemployment among young males is presently (April 1978) estimated at well over 50 percent. Second, with the vast increase in drug-control programs, especially law enforcement, the serious consequences of drug use have soared. Increases in arrests and convictions have multiplied the numbers of young minority people carrying the adverse stigma of being ex-junkies and ex-convicts. The implications are that these adverse results of drug use are greater even if the number of drug users remains stable.

Finally, we can only conclude that the evidence points clearly to the fact that, because of the magnitude of the difference in drug use and because of the infinitely more severe consequences of drug abuse between the dominant society and the minority communities, drugs must be considered from totally different perspectives . Once this premise is accepted, it is then clear that entirely different approaches to the problem are necessary.

DRUG LAWS AS REPRESSIVE TO MINORITY COMMUNITIES

Return to class we must, where public policy is the stratagem of class conflict and law enforcement the weapon, as sharp as the exclusion campaigns against Chinese and Mexicans, or the repression of ghetto blacks. . . Not science but mythology potentiates this history and the social forces whose movements it records. If the monkey on the man's back were only the drug, he would still be a free man.

— Helmer 1975

We further agree with the position, so well stated by Helmer, that:

Narcotics use in America has always, both before and after the Harrison Act, been predominantly a working-class phenomenon. This has been a specific cause, not a general consequence, of narcotics prohibition.

The historical connection between repressive drug laws and racist American attitudes has been well documented (Musto 1973; Bonnie and Whitehead 1974). The point here is to place this all too obvious fact as a backdrop to the present situation, particularly Nixon's insidious war on the junkie as a political enemy. This racist-inspired, politically motivated conspiracy was an integral part of the Nixon-Agnew crusade against crime in the streets, and a natural consequence of more than 60 years of public policies which were based on bigotry,

fear, and worse, the ascendancy of the medical control in "the sale and supply of all medical services, including drugs." Add to this the "expansion of police powers, under political authority , to coerce all aspects of working-class behavior, including drug consumption," and you have a most efficient social-control combination.

Consider, as evidence, the following facts about the disproportionate impact of repressive drug laws on minorities:

• Arrests on heroin charges show an even higher proportion of minorities than the treatment statistics (CODAP, DAWN, DARP). A 1971 study of opiate arrests in six major cities showed 81 percent non-whites; the Drug Enforcement Administration's listing of active narcotic users indicates 55 percent blacks; however, this latter figure does not include other minorities, which we estimate at about 25 percent.

• Penalties for opiate possession and sale are severe and have not been eased as have marihuana penalties, which have fallen dramatically.

• "The difference in race distribution . . . grows more radical as we descend into more local and specific treatment data," report Gibson and Hunt (1977). Citing a Johns Hopkins University study, they note that minorities comprise 66 percent of those on methadone maintenance, but well under 50 percent in other treatment modalities. The repression of minorities appears to be chemically as well as legally based.

• There is strong reason to believe that minorities are disproportionately represented in the prison population for drug charges and that the proportion of minorities is even greater than for arrests.

Item : In New York State, in 1974 and 1975, 71 percent of those admitted on drug charges to State prisons were black or Puerto Rican[1]

Item : A survey of inmates in State prisons indicates that of 18,807 inmates serving drug sentences, 40 percent were black, 15 percent were Hispanic, and 1 percent were other nonwhite. Of those with only heroin charges, 54 percent were black (no Hispanic breakdown was given).

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[1]New York State Department of Correctional Services, Division of Program Planning, Evaluation, and Research. Characteristics of New Commitments, 1974 and 1975 . Albany, N.Y.

THE DOMINANT SOCIETY HAS TRADITIONALLY AND PERVASIVELY CONTROLLED THE DRUG-ABUSE FIELD

There has never been, since the passage of the Harrison Act in 1914, a member of any minority group in any position of leadership in the field of drug- abuse control, treatment, or prevention. This statement carries right through to this day, under an administration proclaiming human rights as a priority across the world. The top six policymakers at the National Institute on Drug Abuse, as well as the so-called "principals," Dogoloff (ODAP), Besteman (NIDA), Bensinger (DEA), Falco (State), the entire staff of the recently phased out Office of Drug Abuse Policy, and over 90 percent of the top three staff in all of the single state agencies, are from the dominant society.[2]

This in spite of the fact that there are, at this point, several individuals from minority communities with excellent credentials, something which was always denied in the past: "If only we could find qualified individuals. . ."

Further, we find that the medical profession is in firm control, espousing a medical approach to the problem and generally relegating the social causes of drug abuse to a distant second.

THE EXCLUSION OF MINORITIES AND THE RESULTING LACK OF RESPONSE TO MINORITY NEEDS

A recent prevention policy position paper from the Office of Drug Abuse Policy serves as an excellent example of how lack of significant minority input can lead to national policies which miss the mark.'[3]

Although admitting that "persons will not use drugs destructively ... if they feel good about themselves and what they are doing, if they think regular intoxication will interfere with their life objectives, and if they find their 'straight' life more meaningful than their 'stoned' experiences," they go on to enunciate four "general goals" which are so middle class in conception and expression that

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[2]*Quoted from "Survey of Inmates in State Correctional Facilities," conducted by the Bureau of the Census for LEAA 1974, in a personal communication to the National Association of Puerto Rican Drug Abuse Programs from the Crime Analysis Section, June 14, 1968.

[3]Creative Socio-Medics, An Assessment of the Statewide Services Contract System and Minority Needs . Final report to the National Institute on Drug Abuse (contract no. 271- 77-12lb). April, 1978.

they have no relationship at all to the minority communities.

They wax ideally of "enhancing personal experience. . . highlighting the ability to live meaningfully and constructively without drug dependence."

Which brings to mind a close friend who was attempting to do just that, in East Harlem— a poet, a painter, a photographer, an intelligent, wise, and gentle 24-year-old, who, for no good reason fell into the hands of the police and was said to have hanged himself with his hands cuffed behind his back. A grand jury exonerated the guilty. They go on to say, in this white paper, that "enhancing family experience" is a desirable goal — "a secure, loving and communicative interaction among parents and children; increasing parental effectiveness, adult-role modeling and family concern." Go tell that to a 30-year-old black woman in Harlem, with six children and no man in the house, living on the edge of disaster daily, with no hope of ever breaking out of the vicious cycle of poverty.

There is more: "enhancing institutional experience" is another laudable goal— "enhancing the climate of both the school and the neighborhood to offer excitement in learning, hope in vocation, and opportunity for growth and success in the adult world."

I offer as further evidence of the distance between the framers of this document and the realities of life in the ghetto the shocking disintegration of the educational system as well as the physical and moral deterioration of those places euphemistically termed the "inner cities." But the absolute understatement of the year comes right on the heels of this trumpeting to higher middle class values: "There is reason to believe" (careful, now) "that deficiencies in these four areas" (the goals stated) "are correlated with potential drug abuse." Whew! The fact is that they are directly related , and that this kind of weak-knee-jerk, half admission of the real causes probably does more harm than good.

- Office of Drug Abuse Policy, "Prevention Policy Position Paper" undated and incorporated, in large substance, in Drug Use Patterns, Consequences and the Federal Response , 1978. (See References.)

This paper is full of examples which can only be labeled "well meaning but misdirected." As a final sop, they devote exactly one-half page to "special populations," where they acknowledge that: drug abuse is often more severe among subcultural and ethnic groups, especially those with more limited economic and social resources.

Yes, it is: Puerto Ricans run a factor of 10 times higher risk of becoming addicted than whites; blacks run an 8 times factor.[4] This lack of sensitivity, this timidity at facing facts, this obviously colorblind position paper was to a great degree the product of an ODAP conference attended by approximately 20 experts in the prevention field. This writer was in attendance, invited at the last moment, and after much pulling and tugging, obtained general agreement that the issues were so different in the minority communities that a totally different approach to prevention was essential. The efforts, obviously, were in vain.

ODAP's policy review, a product of a demand reduction task force, entitled "Drug Use Patterns, Consequences and the Federal Response," (1978) admits that “in general it was apparent that little definitive information exists regarding use, misuse, and abuse of drugs by these special population groups." (pp. 35, 36). And on the 314 pages devoted to "ethnic minorities" (out of a total volume of 130 pages) hey further admit that:

an assessment of the drug abuse problem in ethnic minority communities is a complex and difficult task. One contributing problem has been the lack of research information and data to clarify the nature of the drug problem in the minority communities.

This is followed by a statement which closely matches the one quoted above (from the prevention paper) for just plain jelly: "This has somewhat hampered management efforts to make drug abuse programs and resources of the Federal Government available, accessible, sensitive, and relevant to minority community concerns." (!!!) They proceed from there with gay abandon, quoting a meaningless profusion of disconnected data, probably to indicate some awareness of the facts (pp. 44-47). And yet, in spite of the admission of a lack of ethnic minority data, not one word is mentioned under the research section regarding this unmet need.

Instead, NIDA is lauded for its past efforts:

Among the most important findings of NIDA (See footnote 3) sponsored research to date have been: the discovery of opiate receptor-sites in the brain, the development of narcotic antagonists, testing of animal models detecting abuse

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[4]Creative Socio-Medics, The Nature of the Drug Abuse Problem for Asian-Americans, Native Americans, and Puerto Ricans . For the National Institute on Drug Abuse (contract no. ADM 271-76-4415). 1977.

potential of drugs in humans, development of analytical methods to find drugs in biological specimens, the study of the major psychoactive ingredient in marihuana, the voluntary drug-dependence remission of the addicted Vietnam veteran and the discovery of new narcotic maintenance therapies.

It suddenly becomes crystal clear why there is such a lack of socially oriented, cause-driven research which could provide some light on drug abuse in the ethnic minority communities.

Another $38 million is slated to be spent this coming year, with no commitment to any effort in this regard.

In a speech delivered at the national drug abuse conference in San Francisco in 1977 this writer concluded:

We, in effect, have no choice but to believe that the basic assumptions upon which policies are formulated were inaccurate, producing policies which were off the mark and priorities which were topsy-turvy. So, after all is said we are left with the hard fact that we, who have always borne the brunt of the problem, continue to suffer, even to a greater degree, the crippling consequences of the mis-use of drugs.

THE STATEWIDE SERVICES CONTRACT SYSTEMS, THE STATE DRUG ABUSE AUTHORITIES, AND MINORITY PROGRAMS

A recent study commissioned by NIDA documented a number of problems and inequities encountered by minority treatment programs at the State and local levels. Generally, it boils down to, at best, lack of sensitivity to minority needs from a structure that is overwhelmingly white (over 90 percent of the State directors are from the dominant society). In spite of all of this, the HEW civil rights regional offices (10 of them) have been regularly signing off on all States as being in compliance with all laws, rules, and regulations concerning civil rights and affirmative-action requirements. Somewhere, someone is lying. Further, most minority programs are small, with the problems inherent in all small programs. Among these were:

delays in reimbursement for service providers; burdensome paperwork requirements; inadequate access to policy makers resulting in unresponsive decisions about the nature and extent of services provided to segments of the abuser population; insufficient technical assistance; and an over-emphasis on program management reviews.

Further, these programs are "unlikely to receive special funding considerations from private groups or to develop an internal fundraising capability." A good reason for this failure is the abysmal lack of data: "Treatment programs pressed to meet daily operational costs cannot allocate funds to perform or purchase incidence/prevalence surveys or other research designed to assess needs . . .

Insufficient data about the drug abuse problem within their specific group, then, hamper efforts to seek continued funds, add innovative services, or promote interest in ethnic minority-specific problems." The differences between majority and minority programs were many:

Majority programs appeared to be more effective at obtaining third-party reimbursements and in including third-party money in their program accounting to maximize budgetary flexibility. By contrast, ethnic minority programs were frustrated in their attempts to secure third-party money (again, the administrative, paper-work burden was mentioned) and, when secured in handling these dollars in program accounting. One program had stopped pursuing third-party reimbursements because the work involved was not leading to any programmatic benefits.

Other important operational differences included the ability of majority programs to manipulate the financial world (the use of overdrafts and low-interest loans) and the use of specialists, while ethnic minority programs attempt to get along as best they could with "untrained generalists." Majority programs had few difficulties recruiting staff, where minority programs had severe problems in that regard. Staff turnover was "a problem."

In the face of these and a myriad of other problems besetting the small minority treatment programs, the logical response from the States would be one of assistance, first in identifying, through the State-plan process, the minority needs (by conducting a needs assessment), then by either enriching or supporting these programs (by providing ample technical assistance) or by starting new ones where needed. The facts, as documented in this study, are that there was no specific minority input in 75 percent of the State plans. And, "while more than three-fourths of the States presented indicator data broken down by race ethnicity, only half (55 percent) of the States specified ethnic minority group needs in the needs-assessment section of the Plan." Lastly, less than half the States established goals and objectives for ethnic minorities.

In response to the continuing critical needs and concerns expressed here and elsewhere, the National Coalition of Ethnic Drug Abuse Associations (NCEDAA) was organized in May 1977 at the National Drug Abuse Conference in San Francisco. In their letter to Dr. Peter Bourne, former director of ODAP, announcing the formation of the group and requesting a meeting, they stated the primary reason for the action: "An analysis of some of the most glaring failures exposes a common denominator: the exclusion of our representatives from the policy formulation and implementation process. This has resulted in an insensitivity and lack of understanding of the needs which hamper our efforts to deal with the problem." In subsequent meetings since then the organization has agreed on the major purposes and goals:

• To impact upon the national drug abuse policy structure;

• To define issues from a minority perspective;

• To identify problems hindering effective delivery of services to minority and other underserved communities;

• To offer new approaches toward solution of the problem.

The major thrust, however, was emphasized in a letter to Peter Bourne in which a forthcoming meeting's agenda was discussed: ". . .it has become quite clear to us that there is one overriding issue that is of such importance that we feel it must be resolved before we can address any others. We refer to the question of how we, the representatives of the most affected communities, can penetrate the policymaking/ implementation process which has been closed to us in the past."[5]

In effect, then, the Coalition Steering Committee (see list at end of chapter) as well as a number of others, considers the issue of representation at the national level of such importance that it stands far above all the others.

Since July 1977, the coalition met in Washington, D.C. with Dr. Peter Bourne and ODAP on four occasions and, although a number of issues were

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[5]Frank Espada letter to Dr. Peter Bourne on behalf of the National Coalition of Ethnic Drug Abuse Associations, July 1, 1977.

discussed, no clearly discernible pattern has emerged which can predict how minority input can be formalized. In the first meeting, held at the Theodore Roosevelt Room at the White House, the coalition attempted to secure official recognition as a legitimate entity representing the interests of a significant number of the victims of drug abuse. Instead, it received a warm welcome and a standard bureacratic putoff: "We welcome your group's input as well as a number of other groups we have to deal with." There are no other minority associations outside of NCEDAA.

However, in fairness to Dr. Bourne, were it not for his efforts, NCEDAA would not have penetrated as far as it has. Because of Bourne's obvious support, NIDA responded with a contract to Creative Socio-Medics, which produced the data relating to the statewide services contract system. Further, the coalition has played a major role in the planning of the National Drug Abuse Conference, which was, until last year, the province of a small elitist group who felt they had a proprietary right to setting the tone and direction of the conferences. In fact, NCEDAA has been a strong force in the democratization of the most important meeting of the year.

Participation in both the White House and the conferences has projected some of the coalition's leadership onto the national stage in the drug-abuse field. It is a strange and welcome sight to finally begin to see those representatives at the forefront, although they still are not in positions of great responsibility nationally.

I'd like to close this section with a quote from this writer's speech at last year's conference in San Francisco:

It is high time, then, to break with tradition, to begin to include those within our society who are neither politically influential nor economically powerful in the development and implementation of public policies. Let's open up the process to responsible, qualified individuals from these communities who are forever ignored and whose destinies are always determined by others. The victims of drugs have no constituency. Listen to those who can, in some way, speak for them.

SOME IMPLICATIONS FOR FUTURE RESEARCH, TREATMENT, AND PREVENTION

The implications, to us at least, are clear; whether we'll be listened to is another matter. Personally, I have strong doubts, since I have always believed that power yields nothing, that those in the driver's seat will not even make room at the top, much less give it up. And the fact is that there is too much at stake here. All of the ingredients are there: money, prestige, position— in short, power. It has always been in the hands of the dominant society; there is little hope to believe things will change. We've gone the only route open to us: organization. In the past we learned to compensate, in small measure, for our political and economic weaknesses through organization of various kinds. Then, we believed those who were threatened by bur political potential and we stopped organizing because it was "out of style." Well, it never was and never will be out of style. To some degree we have proven this with NCEDAA. It remains to be seen how far we can take it.

The implications for future research are there for anyone to see. Little or no socially oriented research has been done on the causes of drug abuse in the minority communities. What has been done has been ill-conceived, by non-minorities, having no credibility in those communities.

The basic research problem is conceptual . As long as the top leadership levels continue to follow a medical-technological orientation to drugs, the minority perspective will be neglected. This holds for researchers as well as bureaucrats, but since most drug research is Government financed and monitored, the ultimate responsibility rests at the top policymaking levels. The lack of conceptual awareness is reflected in requests for proposals which seldom seem to address minority concerns; in the past and present funding allocations; and in the lack of receptivity to minority perspectives on those rare occasions when they have been presented to Government bureaucracies.

A change in the basic conceptions would certainly change research orientations. But, since it is unrealistic to expect a bureaucracy like NIDA to instantly and intelligently reverse directions, the following suggestions are made with the understanding that change will be slow, and that what is sought is specific programing and not basic reorientations.

Within the existing budget for drug research, priorities must be changed . The vast amounts spent on medical-technological research (such as on narcotic

antagonists, cannabinoid assays, etc.) should be rapidly phased out. I do not have all the answers regarding what research is irrelevant or harmful to minorities, or what alternative research should get top priority, but it appears that NIDA has no clue of what is needed either. Therefore, NIDA's role should be to bring together minority leaders and sensitive researchers to review current research allocations and determine future strategy.

The following steps can be taken immediately:

(1) Institutionally, NIDA should restructure research review boards so that there is a reversal of the current situation in which minority-oriented research is reviewed by overwhelmingly white medical-pharmacological technocrats.

(2) A minority research center should be created, outside Government, to help define minority research needs on an ongoing basis, to conduct some independent research, and to insure that ongoing and future research projects are as relevant to minorities as possible. This center should communicate to minorities the state of research as it affects them.

(3) Past research on drugs— at all levels of the treatment and criminal justice system— should be re-analyzed from a minority perspective. There is a mountain of inadequately analyzed data on which racial or ethnic differences have been coded but barely looked into. In several reports and speeches I have begun the re-analysis of DAWN (and to a lesser degree, CODAP), but the task is enormous and time consuming. However, it is far less expensive than conducting new research, and the result we anticipate will clearly show a need for a minority focus.

A new style of research, in which issues are redefined and considered from minority community viewpoints, is necessary if research data are to capture a sense of reality and relevance to those communities. This means breaking away from using established categories, formal questionnaires, "rock hard" data from statistics to urines, and reliance on computers. This new approach should have a strong ethnographic research component rather than removing the individual— the causes of drug use— from the community and social setting. This new research would have as its goal the determination of the interplay between social context and drug use, as well as the impact of drug policies on minority individuals and communities. People who could take this ground-level perspective must be trained because very few now exist who can undertake such research.

The weight of past evidence and my own personal experiences reinforce my belief that understanding comes from below or within; that there is a chasm from the heights of government to the depths of some streets which has yet to be bridged. NIDA should not determine the style and content of the research and should not try to keep the research "in house" or parcel it out, in drips and drabs, to nearby firms they have close control over.

The implications for treatment are spelled out in the Creative Socio-Medics study of the statewide services contract system. (See footnote 3) Primarily it recommends more participation by the drug treatment minority community at the State and local level. Further, it underlines the special needs of the small, minority programs. Assistance of all kinds is needed: technical assistance, primarily by minority experts, training in management, evaluation, organizational skills, etc. And States must comply with the law and include minorities at the top levels of the State drug abuse agencies. State plans must take into consideration the special needs of these programs. NIDA can condition the statewide services contracts to assure many of these things actually take place.

Prevention strategies which are thought through and implemented by minorities for minorities must be tried. No one has solved the riddle of prevention. Very little seems to have worked. It is time minorities had a go at it.

I'd like to think, in closing, that things will never be the same again. That the advent of the minorities at the San Francisco Drug Abuse Conference last year marked a turning point in the direction of this field. That my being asked to write this paper is a step forward and that the accessibility we have gained over the past year is not illusory. However, I've seen gains evaporate before, hopes squelched, people turn bitter and cynical with a process that keeps changing rules just as one thinks one has it figured out. All we can do is hope that this time things will be different: that those presently in control really want change.

And we can keep the pressure on.

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