

WHERE DOES ONE RUN WHEN HE'S ALREADY IN THE PROMISED LAND

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During the last four years I have participated in an effort to end the heroin addiction epidemic in the District of Columbia (1,2,3,4). Now that the effort appears to be drawing to a successful conclusion, I am increasingly fascinated by our adversary. A moment's reflection reveals how little we know about this epidemic. In recent years, as heroin addiction has become front page news many have tried to hoist their political flags on the heroin problem. Some have seen heroin addiction as a symptom of racism or social class discrimination, others consider it a byproduct of the Vietnam War, or a symptom of the deterioration in the moral fabric of American society, or the result of growing permissiveness. Some see it as the result of a communist or white-racist genocidal plot.

We can understand more about the modern heroin addiction epidemic by studying the urban context in which it occurred. This study reveals that not only heroin addiction but also crime and welfare dependency -- the human problem of the cities -- are affecting the same relatively small, well-defined segment of the population.

The data I will present today is drawn from the District of Columbia. In terms of heroin addiction and other social problems, the Nation's Capitol appears to be typical of other urban centers in the country, thus it is possible to generalize from this experience to most other American cities.

Since its records were computerized in 1971, the Narcotics Treatment Administration (NTA) has treated 13,000 District of Columbia residents for heroin addiction. There have been a total of about 18,000 heroin addicts in Washington during the last four years (5).

There are several conclusions which can be drawn about heroin addiction in the District of Columbia. First, while heroin addiction exists in virtually all segments of the population between the ages of 10 and 70, it is highly concentrated

among lower class young men. The racial and ethnic composition of the heroin addicted population in American cities closely reflects the racial and ethnic make-up of the local lower class population. In Washington the lower class is predominantly black (6). Although public concern in the last few years has focused on heroin addiction among returning Vietnam veterans and on the spread of heroin addiction out of the ghettos into the middle class suburbs, neither of these developments contributed more than a small fraction to the total heroin addiction problem in Washington (7). Second, heroin addiction has been part of urban life in Washington at least since the start of World War II. However, there was a dramatic increase in the rate of new cases of heroin addiction in the mid-1960's which peaked in 1969 when over 2,500 people first used heroin in the District of Columbia (8). Third, the first use of heroin by specific individuals occurred primarily between the ages of 16 and 21. Fourth, heroin addiction spreads primarily within adolescent peer groups by person to person contact with the new user as the primary contagion carrier (9). Finally, there is a growing body of evidence that the heroin addiction epidemic is now rapidly declining in the District of Columbia. This data about the decline in heroin addiction, plus related information about methadone overdose deaths and amphetamine abuse, has been presented elsewhere at this Conference (10,11,12). Who are these people who were late adolescents between 1966 and 1970, these "epidemic" heroin addicts? Combining the data on the year of first heroin use with the data on age at first heroin use, it is apparent that the "epidemic" addicts were born between the years 1945 and 1954.

In the District of Columbia the peak attack rate occurred among the 5,700 males born in 1953. Of these men, about 5% became addicted to heroin in the single year 1969. By 1972 a total of 13.5% of these young men had been treated by NTA for heroin addiction. Overall, there were about 147,000 people born in the decade following World War II who grew up in the District of Columbia during the 1960's. About 10.5% of the males and about 1.9% of the females in this cohort became heroin addicts and were treated at NTA by 1972. In large sections of Washington, the prevalence of heroin use was over twice the city-wide rate (6). Thus in these areas more than a quarter of the males born in 1953 became addicted to heroin. Preliminary data on pre-epidemic years showed that the city-wide attack rate for adolescent males was about 0.2% per year as opposed to the peak rate during the epidemic of over 5% per year. Thus the epidemic attack rate was about 25 times the non-epidemic rate.

This 1945 to 1954 birth cohort is the post World War II baby boom, the peak of the steadily rising local and national

fertility rates between 1935 and 1957. In the District of Columbia and in other cities many from this cohort are the children born to the men and women who migrated from the rural south to the Promised Land of the northern cities after the Great Depression.

#### What Was The Urban Context of the Heroin Addiction Epidemic?

Between World War II and 1972 there were several major population shifts in the Washington Metropolitan Area. These trends were similar to those in other large cities. The proportion of total metropolitan population which was black remained constant at about 25% since at least 1900. However, since 1950 the Washington metropolitan population more than doubled to over 3,000,000 while the District of Columbia population fell slightly from 802,000 to 756,000. In 1950 35% of the District of Columbia population was black whereas in 1970 the District of Columbia was 71% black. The black population grew proportionately with the white population in the Washington metropolitan area, however the black population was concentrated in the center of the metropolitan area and gradually spread outward (13). It is important to recognize that this shift to a predominantly black population was not associated with a dramatic shift from middle class status to lower class status in the city as a whole. For example, the median education level for adult blacks in the District of Columbia in 1970 was 11.4 years which was up from 8.8 years in 1950. Similarly the number of black adults who completed college rose in the District of Columbia from 10,000 in 1950 to 22,000 in 1970. There was a similar rise in income (adjusted for inflation) for black families from \$2,200 in 1949 to \$6,500 in 1969. The most dramatic development in the population in the District of Columbia in the last two decades was the development of a large black middle class. Thus, while the lower class population in the District of Columbia today is predominantly black, the black population in the city is not predominantly lower class.

Most of the black migrants to the District of Columbia and other cities improved their living conditions as the result of their move (14). The unemployment rate in Washington was generally low during this migration. For example in 1970, when there was substantial national unemployment, the unemployment rate in the District of Columbia for black men aged 20 to 59 was 4.5% and for black women it was 3.6% (13).

In addition to these racial and social class developments, there was a dramatic shift in the age structure of the District of Columbia population between 1960 and 1970. The post World War II baby boom and selective migration pushed the

number of people between the ages of 16 and 21 from 65,000 in 1960 to 86,000 in 1970. Expressed in terms of percent of the total population this group increased from 8.5% to 11.4%. Expressed in terms of percent change this group in the population rose 32.2% during the decade of the 1960's while the total D. C. population remained about constant.

Thus in the late 1960's there was a sharp rise in the number of people in the population who were in the age group most susceptible to heroin addiction, 16 to 21 years old.

This sharp rise in the number of adolescents in the population was accompanied by an equally sharp fall in the number of adults between the ages of 30 and 50 (13). This reflected the relatively low national birth rates of the 1920's and 1930's.

What happened when this population wave entered their teenage years in the mid-1960's, a period when there were relatively few adults? It is hard to overstate the impact of these demographic shifts on a wide variety of social institutions in the District of Columbia and elsewhere in the country. One of the first changes in Washington occurred in the junior high schools which had a rise in the rate of dropouts beginning in 1962, peaking in 1964 and falling to a lower level by 1969. A similar phenomenon occurred in the senior high schools though it began a few years later and peaked in 1968. Slightly later there was a much more profound increase in the rate of new heroin addiction peaking in 1969. The rate of serious crime started dramatically up in 1966 and also peaked in 1969.

The young people born after the Second World War entered the labor market at an ideal time -- a period of generally low unemployment. The overall unemployment rate in the District of Columbia during the 1960's of about 3% was even lower than the national average. However, these averages concealed an important development -- there was a rise in the gap between the unemployment rate for all adults and the unemployment rate for teenagers. The unemployment rate for black individuals aged 16 to 21 was about 8% during the early 1950's but it rose steadily during the 1960's until the unemployment rate for black individuals aged 16 to 21 was 16% for males and 20% for females in the District of Columbia in 1970.

We now know that many of the young men in this birth cohort became heroin addicts. What became of the women? They were the individuals who in recent years ballooned the welfare roles in the District of Columbia and other cities throughout the nation. From the beginning of the federal welfare program in the 1930's the typical welfare recipient was either a disabled

individual or a woman who had been married but who had lost her husband (through death, imprisonment, desertion, etc.) and who raised her children with the help of the Aid for the Families of Dependent Children (AFDC) program. This pattern changed in the late 1960's as thousands of young women, most of whom had never been married, went on AFDC.

Between 1961 and 1971 there was a rise in the total number of women receiving AFDC support in the District of Columbia from 5,000 to about 16,300. AFDC utilization by women of all ages during this decade increased as court rulings, administrative regulations and public attitudes all shifted to permit more of those eligible for the AFDC program to actually use it. However, the largest growth occurred among younger women. For example, the number of women receiving AFDC over the age of 30 increased by 140% in the decade ending in 1971. Among the women less than 30 years of age the increase was 303%. Among women aged 20 or less the increase was 800% from 290 in 1961 to about 2600 in 1971. Expressed somewhat differently the most frequent age of women on AFDC in 1961 was 30 but in 1971 it was only 23. Thus in 1971 the single most frequent year of birth for women on AFDC in the District of Columbia was 1948 -- well within the post World War II birth cohort (15).

In 1971 about 6,000 women born between the years 1945 and 1954 were on AFDC. In that same year about 9,600 men and about 2,400 women from this same birth cohort were addicted to heroin. About one-third of the women on heroin were also on AFDC. A total of about 17,200 (or 11.7%) of the 147,000 individuals then living in the District of Columbia who were born between 1945 and 1954 were on heroin or public assistance or both in 1971.

Thus while almost 12% of this age group were on welfare or heroin in 1971, the more important fact is that the large majority of the young men and women, both black and white, who grew up in the District of Columbia in the decades following World War II weathered these troubled years without either going on heroin or welfare.

Why were both welfare and heroin addiction concentrated in this age and social class group? The generation that was born following the Second World War faced many unique challenges. It was, for example, the first generation which grew up watching television, and it was the generation which fought the Viet Nam War. But only part of this generation suffered from heroin addiction. This part was primarily made up of black and Spanish speaking immigrants who lived in the centers of America's cities -- areas left to them by the movement to the suburbs of earlier immigrant groups. For these youths growing up during the last decade was even more complex and more difficult than it was for other, more fortunate, Americans of the same age. Lower class, inner city youths in the 1960's faced a monumental accumulation of neglect and discrimination and they lacked cultural guidelines.

They were also the generation most directly affected by the promise of the Great Society social programs. A rising sense of entitlement to middle class status was reenforced for this group by social activism and by their heavy exposure to television. These first and second generation immigrants from rural poverty were a uniquely vulnerable group.

Since the early 1920's, in America being a heroin addict meant more than being physiologically dependent on an opiate drug. It meant the willingness and ability to adopt the lifestyle of the street addict which included crime and participation in the underworld supply system. Being a street addict virtually prohibited pursuit of more conventional goals including work and family. The American street addict role was unacceptable to most people but during the 1960's it became more acceptable to some lower class youths. For many of these lower class, inner city people during the last decade the "costs" of a career as a street heroin addict or a welfare mother were slight when weighed against the immediately available alternatives of education and employment. The career calculation went differently for both the black and white middle class. They had much to lose if they chose heroin addiction or welfare. It is no wonder, then, that heroin addiction and welfare are tied so closely to the problems of race and youth in American cities. It is also no wonder that these issues have been so highly politicized in recent years.

I began this account by observing that I have spent the last four years participating in a struggle to end the heroin addiction epidemic in Washington. My colleagues include many men and women from this age group who have been caught in addiction themselves. As I have worked with them I have learned to respect their strength and the difficulty of their struggle. Social institutions must help. However, we must also recognize that social institutions depend ultimately on the strengths of the people they serve and this group, despite its vulnerability, has great resources of strength.

#### What Lessons Can Be Learned from the Heroin Addiction Epidemic?

The information I have briefly reviewed today strongly suggests that one of the major causes of the rapid rise of heroin addiction in the District of Columbia and other American cities during the 1960's was a major demographic shift which increased the number and proportion of teenagers in the population. The teenagers who lived in the center cities, who were poor and primarily first and second generation black and Spanish speaking immigrants were particularly susceptible to the modern contagion, heroin addiction. The forces in the inner city community which

had inhibited the spread of heroin addiction in earlier decades were weakened in the 1960's and the epidemic spread alarmingly, reaching a peak when, in large parts of Washington, over one quarter of the individuals born in a single year became addicted to heroin. Heroin addiction was a central part of the chain reaction of social disorganization in the 1960's.

One obvious cause of the rapid spread of addiction was the high unemployment rate among these youths during the 1960's. The rise in the number of young people in the Washington population, plus the social factors described earlier appeared to set the stage for the heroin addiction epidemic. There were other factors which played a role in the epidemic including the rapid rise in the supply of heroin to meet the increased demand plus the psychological and biological conditions in particular individuals which made them the ones in their age and social class group who actually became addicted. The resulting sudden spread of addiction triggered many responses which led to a sharp reduction in the attack rate in the District of Columbia in 1971 and 1972.

The reduction in heroin use in Washington occurred despite continuing increases in the teenage unemployment and despite continuing high numbers of teenagers in the population. Treatment unhooked the addict from the pusher and from crime. A major local, national, and international law enforcement effort reduced the supply of heroin in the city (10). Perhaps most importantly, among the susceptible youngsters there was a rapid growth of awareness of the dangers of addiction which made otherwise susceptible youths unwilling to experiment with heroin. It is one thing to grow up knowing that there is an older fellow in the next block who is addicted to heroin and quite another thing to have many of your friends strung out, in jail, or even dead from an overdose. Perhaps it took several years for the most appalling consequences of heroin addiction to develop and become obvious to the susceptible age group. Once it was obvious a cultural immunity developed.

The recent growth of dependency on public assistance may have similar roots -- it certainly affected the same age and social group disproportionately. But welfare has shown no decline similar to the recent decline in heroin addiction. Is this because the negative consequences of welfare dependency are less obvious to the peer group? Perhaps it is harder to get off welfare because of the financial "trap" which makes it so difficult to give up welfare for the realistically available alternatives for these lower class youths.

In any event the overwhelming conclusion of this analysis is that many of the serious problems which we have come to think of as the "social" problems of America today including crime, heroin addiction, and welfare dependency, are primarily affecting the same relatively small group in the population. Perhaps as we can focus our attention clearly on this group of individuals and develop specific techniques to meet their needs we will be able to reduce these problems as we have been able to reduce the problems of heroin addiction in the District of Columbia and other cities. It is quite unlikely that we will be able to solve these problems as long as we see them in vague, highly politicized terms.

It is also obvious that we need to have better warning systems which can detect major demographic shifts in the population and alert us to emergent problems before particular institutions are overwhelmed. Similarly we need systems which will identify drug use patterns early so that drug abuse epidemics do not rage out of control for years before they are recognized.

In addition, what are the policy implications of this analysis? There are two distinctly different approaches to reducing contemporary social problems such as heroin addiction, crime, and welfare dependency. The first approach is to make these courses of action more difficult. For example, heroin addiction becomes more difficult when heroin is less available, when law enforcement increases the risk of imprisonment for possession or sale of the drug and when law enforcement becomes more effective in punishing those who commit crimes to support their habits. Similarly heroin addiction becomes more difficult when the community rejects the addict's life-style.

The second approach is to increase the availability and attractiveness of alternative courses of action. For example, making education more attractive and effective would increase the number of poor young men who chose school over addiction. Increased availability of meaningful work for the young will reduce the relative attractiveness of addiction. Heroin addiction treatment enables addicts to chose alternatives to the street addict role.

These two approaches can be broadly defined as tough or repressive on the one hand, and soft or humanitarian on the other hand. They can be applied to crime and welfare dependency as well as to heroin addiction. They are not mutually exclusive alternatives. Most of us in the field of heroin addiction treatment agree that a balanced policy including both approaches is necessary to deal with the heroin epidemic.



The political forces relating to these social problems are strong and tend to be polarized. By having our facts clear we can support a balanced approach to these problems and avoid an unbalanced tough approach to the problems which would leave a large number of young, lower class men both out of school and out of work even though they were not on heroin. Perhaps an increase in violent gang activity would be one result of this approach. Similarly an unbalanced humanitarian approach might lead to a sharp rise in the sense of entitlement of one segment of the society producing grave conflicts with other less favored groups in the population. In any event, exclusive reliance on the humanitarian approach would do little to stop the immediate destructive effects of heroin addiction.

Let me conclude by quoting from Claude Brown whose brilliant book Manchild in the Promised Land chronicled the experience of the generation I have dealt with in this paper (16):

"I want to talk about the first northern urban generation of Negroes. I want to talk about the experiences of a misplaced generation, of a misplaced people in an extremely complex and confused society. This is a story of their searching, their dreams, their sorrows, their small and futile rebellions, and their endless battle to establish their own place in America's greatest metropolis -- and in America itself.

"The characters are sons and daughters of former Southern sharecroppers. These were the poorest people of the South, who poured into New York City during the decade following the Great Depression.....The children of these disillusioned colored pioneers inherited the total lot of their parents -- the disappointments, the anger. For where does one run to when he's already in the promised land?"

Many of the people Claude Brown wrote about are at this Conference today and many of them, through their work developing themselves and their communities, are answering Claude Brown's haunting question, "Where does one run when he's already in the promised land?" They are not running to the promised land. They are creating it.