Social Behavior, Public Policy, and Nonharmful Drug Use

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A CENTRAL FEATURE OF AMERICAN DRUG POLICY has been the doctrine that the use of mood-modifying drugs like heroin, marijuana, and cocaine is hazardous, likely to lead to socially dysfunctional behavior, health problems, loss of control, and interference with work and other functioning.

The image of the out-of-control drug addict today contrasts with the situation in the early twentieth century, when drugs like opium, cocaine, cannabis, and chloral hydrate were freely available legally. One possible contributor to opium's becoming illegal in the United States was Samuel Gompers's claim that its use by Chinese immigrants increased their productivity so substantially that whites were at a disadvantage in the labor market (Michaels 1987).

How could opium be seen as encouraging productivity at one time and as destructive and antisocial at another? An answer to this question would involve study of the changing climate of opinion toward nonmedical drug use since the closing of the opiate-dispensing clinics in the 1920s. American policy has grown consistently more opposed to nonmedical drug use, decade by decade, culminating in the "zero tolerance" of the 1980s war on drugs, with its targeting of recreational users.

One recurring conclusion of the literature on mood-modifying drugs like heroin and cocaine is that their regular nonmedical use will almost

The Milbank Quarterly, Vol. 69, No. 3, 1991

inevitably lead to bleak personal and social outcomes. My article suggests that the conventional picture of uniformly negative consequences of regular drug use is not supported by the data. Because there are no studies attempting to test the hypothesis that Americans who illegally and regularly take psychoactive substances can do so without incurring significant losses in their lives, the relevant data derive from studies undertaken for other purposes.

A few studies involve persons in treatment interviewed about their former drug use; more of the data derive from investigations of users not in treatment. Although the studies vary in range and quality, they have appeared over a period of more than 60 years and have dealt with many different populations. A number of them were sponsored by government agencies.

Drug Use and the Ability to Work

The effects of regular drug use on work functioning are crucial because of the central role of work in defining social roles and the widespread belief that regular use of mood-modifying drugs is incompatible with the capacity to fulfill employment responsibilities. Two investigations of working addicts involve interviews with persons in treatment and others derive data from drug users in the community.

In one 1950s New York State investigation of 142 drug addicts in treatment, 71 percent were addicted to morphine and 19 percent to barbiturates (Morhous 1953). Physician (28 percent) and businessman (9 percent) were the most frequent occupations. The great majority of subjects worked steadily at their chosen careers and a number had exhibited upward mobility since the onset of addiction. Many entered treatment to reduce, but not to stop, their drug habit.

In a study of the work history of 555 former New York street heroin addicts in treatment, who held full-time jobs for at least three months while addicted, the typical respondent was a male aged 20 to 29; over half were black or Puerto Rican and actively involved in the drug subculture (Caplovitz 1976). Most subjects had held conventional jobs for more than two years and 70 percent held a full-time job for a year while addicted; 71 percent had used heroin while on the job. Most of the respondents felt that drug use made their jobs easier. Fifty-two percent of

the respondents' fellow workers approved or tolerated the drug use and two-fifths of the subjects had bought or sold drugs on the job.

Perhaps the first systematic post-World War I study of the work effectiveness of opiate addicts was conducted by Kolb (1928), who found that three-fourths of the 119 addicts interviewed had good work records. One 66-year-old woman, who had averaged 17 grains of morphine daily for 37 years, was typical; she had long successfully supported herself by working at a job that required substantial physical labor.

The first large-scale social science investigation of opiate addicts, who typically injected the drug and had been users for over five years, was conducted by Dai (1937) in Chicago. More than four-fifths of the 1,887 addicts he studied between 1929 and 1933 were functioning in conventional occupations.

Several decades later, in a statewide study (N = 266) of all the narcotic addicts who could be located in Kentucky, O'Donnell (1969, 132–3) noted that more than nine-tenths of the males receiving drugs legally were working effectively at established occupations. An improvement in work pattern typically followed an addict's securing a stable drug source, suggesting that this facilitated or caused the improved work situation.

In 1969, Arthur D. Little, Inc., was asked to conduct a thorough investigation of heroin addiction for a presidential commission and the National Institute of Mental Health (NIMH). On the basis of a three-year investigation of data from all available sources on the 120,000 addicts in the United States, the project director reported that approximately "30 percent of all the drug abusers actually are legitimate people, in the sense that they have a job which they keep. . . ." (Waldron 1969). These addicts included persons who worked at a wide range of jobs.

An investigation in New Orleans undertook to trace how older opiate addicts, over half of whom were steadily employed and who were not on methadone maintenance, were dealing with their addiction (Capel et al. 1972). The mean age of the men was 59. They adapted their drug use to changing circumstances. Where heroin had been preferred in the past, Dilaudid became popular because it was purer, easier to get, and could be taken orally. A number of addicts only stopped working when they became eligible for Social Security or pension income.

The war in Vietnam, in the 1970s, led to concern about how the widespread use of heroin was affecting the functioning of military personnel. Approximately 19 percent of the enlisted men were addicted to

freely available and inexpensive heroin of 80 to 95 percent purity. By and large, there was no way to determine their addiction by work performance. Urine tests were introduced because the heroin use was otherwise not detectable. "A good many men were able to use narcotics heavily in Vietnam and still function acceptably" (Robins 1974). Undetected heavy users did not differ from occasional users in rates of either disciplinary action or promotions.

Zinberg (1984, 162) interviewed users of opiates and other drugs who took the substances on a controlled basis for an average of several years. Not only did they maintain conventional jobs in the community, but many also had a substantial commitment to work that went beyond earning a living. They valued the status gained from work: "I've done a lot of work in the union . . . I worked hard to get that . . . been with the union for about eight years . . . it doesn't counteract the good feeling that I get from the heroin."

During the period from 1959 to 1964, I led a panel study that investigated prevalence of drug use among functioning workers. When we originally recruited these illicit and regular opiate users from community sources, they were not known to authorities and had not been in treatment (Winick 1960, 1990, 1992). There were 43 physicians, 72 nurses, 94 jazz musicians, and 85 other people working in mass communications and distribution industries. The nurses were all female and the other subjects were all male. Of the 294 subjects, 9 percent were black, 4 percent were Hispanic, and 87 percent were white.

Follow-up interviews were conducted ten years after the first cycle of interviews. At that time, 37 percent of the physicians, 31 percent of the nurses, 35 percent of the musicians, and 27 percent of the other workers were still using opiates. The subjects generally reported that drug use hardly interfered with work functioning. Work dysfunction was mainly caused by an interruption in the availability of drugs. The work demanded the extremely arduous requirements of physicians and nurses, the need for the empathy and improvisational skills of the musicians, the urgent deadlines of mass communications specialists, and the repetitive tasks of warehouse workers.

Individuals in each of these occupational groups tended to use drugs for different but functionally facilitative purposes. One ophthalmic surgeon noted: "With Demerol, I can do three or four perfect operations a day. It builds up my resistance and makes it easier for me to concentrate when I am working double shifts and just couldn't keep up with it. The

drugs help a lot." A trumpeter said: "With the heroin, I could feel and look cool and reach and hold the sound that I wanted." A warehouse worker stated: "It's a very slow and long day, taking plumbing parts out of bins. Without the drugs, I couldn't make it." A television cameraman observed: "I can't make a mistake on the job. I work a lot of overtime and the drugs make it easier for me to concentrate." No doubt other factors in the lives of these study subjects contributed to the relatively prosaic character of their drug habit and enhanced their ability to work: licit occupations, structured schedules, and participation in conventional family and community activities.

That some physicians are drug dependent has been especially troubling. However, in spite of the substantial consumer and professional concern about impaired physicians, there is evidence that some physicians function effectively while drug dependent. One noted case involved "Doctor X," who practiced medicine effectively and successfully for over 60 years (Cutting 1942). There appeared to be no significant professional or personal deficit as a result of his opiate addiction, which paralleled his entire career.

William S. Halsted, the father of modern surgery and a founder of Johns Hopkins Medical School, was cocaine dependent until the age of 34, when he turned to morphine, on which he probably remained continually dependent until his death at age 70. He was professionally active and medically creative during his whole life (Penfield 1969; Ingle 1971).

There are no reports demonstrating that addicted physicians are more likely to commit malpractice than others. Indeed, the country's largest program for addicted medical professionals reports that a physician's professional activities represent the last aspect of his or her life to be affected by drug dependence (Talbott and Wright 1987). Drug-using physicians typically have successful and active primary care practices (Winick 1990). As O'Donnell (1969, 227) noted in his report on addicts in Kentucky, some addicted physicians were described as "the best doctor in town."

A panel study of the natural history of male street addicts known to the authorities (N = 581) was conducted in California (Anglin et al. 1988). The men were interviewed during the period 1974–1975 and again 12 years later. Forty-nine percent were Hispanic, 40 percent Anglo, and 11 percent black. In the month preceding the final interview, 47 percent used marijuana or hashish, 44 percent took heroin, and 22

percent were cocaine users. Half were working full time at a legitimate occupation.

A multisite investigation of 124 urban male intravenous heroin users, not in treatment, found that about 30 percent were usually legitimately employed (Hanson et al. 1985). Their drug use provided stability, a sense of capability, increased drive, and feelings of control over their lives. The street addicts studied by Maddux and Desmond (1981) were employed an average of 62 percent of the time during their first decade of drug use.

If heroin use was the source of the greatest concern in the 1960s and 1970s, crack use seized center stage in the late 1980s. Although smoking crack is the most dependence-producing form of ingestion, it is not incompatible with regular work obligations. A 46-year-old practical nurse was observed driving his fairly new car to a Harlem crack house while parking his other car near his co-op apartment. He had been distilling and smoking cocaine for 22 years. "I smoke at least three times a week," he said. "But I don't chase it. It won't prevent me from going to work tomorrow night, from paying my bills. . . Some people enjoy drinking wine. This is my enjoyment" (Treaster 1991). Among the other regular users at the crack house were social workers, a maintenance man, and other healthy-looking people with conventional jobs.

Finally, in view of concern over marijuana's links to an "amotivational syndrome," it is noteworthy that a psychoanalytic investigation of 150 heavy users of marijuana concluded that daily heavy marijuana use was compatible with significant career success (Hendin et al. 1987). Marijuana use was adaptive in occupations as demanding as corporation lawyer, executive, and theatrical director.

Users Who Are and Are Not in Treatment or Prison

Most studies of illegal drug use are based on retrospective interviews with former users in treatment programs. Users in prison represent another source of subjects. Such persons could be less competent and effective than the far larger number of unreported and unknown drug users. A user who is troubled and not doing well is more likely to seek

help in treatment than someone who is healthy and functioning. Addicts usually enter treatment when their behavior has become dysfunctional (Ellis and Stephens 1976). A less alert user may be more prone to arrest than someone who is effective in "taking care of business."

Most drug dependents never experience either prison or treatment. With approximately 430,000 treatment slots available in the United States, including all modalities, the majority of dependents will not get into treatment. Some 300,000 persons are in prison for drug-related offenses, so that the majority similarly will not be incarcerated. Thus, only about one-tenth of the number of regular users of illicit drugs or unauthorized users of licit drugs could be in prison or treatment at any one time. They could very well be less capable and adaptable than those users not in treatment or prison. Yet, because access to the treatment and prison population is so convenient for researchers, the picture of drug dependents that has emerged from studies of these populations may be incomplete.

To clarify differences between drug dependents within and outside of institutional control, a number of comparisons of treated and untreated users of opiates and cocaine have been made. The largest national survey of young men in the high-risk age group reported that untreated heroin addicts were less likely than those in treatment to have impaired health or family situations (O'Donnell et al. 1976). Another study found that untreated addicts, compared with those in treatment, had more self-esteem, better family situations, and fewer legal problems (Graeven and Graeven 1983).

A New Haven investigation studied heroin addicts in and out of treatment who had drug habits that were comparable in duration, severity, and users' participation in illegal drug-procurement activities. The nontreatment group, however, functioned more effectively in a social context, had fewer legal problems, and was less likely to have dysphoric symptoms or a depressive disorder (Rounsaville and Kleber 1985).

Heavy cocaine users, not in treatment and living in communities participating in the NIMH Epidemiologic Catchment Area (ECA) study, were interviewed and their characteristics compared with those of similar cocaine users who were in treatment (Anthony et al. 1985). The ECA subjects had fewer health, social, psychological, or occupational problems. All relevant studies thus indicate that persons in treatment are less effective in dealing with their lives than street users not in treatment.

Upper-income Drug Users

Because they are not engaging in predatory criminal activity or using publicly supported treatment facilities, upper-income users are relatively invisible. Better information about these people could significantly alter our perception of the effects of drug use. Documentation of substantial drug use without noteworthy negative consequences, in this population, could enable us to make realistic assessments of the extent to which the destructive sequelae of drug use among inner-city residents are likely to reflect their position in the social system rather than the effects of drugs. In spite of widespread publicity given to the heroin and cocaine use of some children of the rich and famous, there are no large-scale studies of the subject. There is, however, at least one impressionistic report on "hidden" affluent young heroin users (Haden-Guest 1983).

Perhaps the only effort to determine the dimensions of drug use among a substantial sample of the upper classes was a statewide survey in New York (Frank et al. 1984). Families with an income of $50,000 per year or more reported more illicit drug use than any other income group. The upper-income group used cocaine at double the rate of the lower-income respondents, probably reflecting its relatively high price at the time. Combinations of substances were also used more heavily among the upper-income groups. Irrespective of measure, people with higher incomes had the most serious drug use, although there was no evidence of comparable levels of dysfunction.

Asked where they would go for help if they needed treatment, 72 percent responded that they would seek out a private professional and 26 percent preferred a self-help group. The larger the user's income, the greater the likelihood of the person going to a private professional. Thus, these upper-class users would not be in a hospital or publicly funded program that contributes to a national data collection system such as the Drug Abuse Research Program (DARP) or the Treatment Oriented Prospective Study (TOPS), the findings of which significantly influence policy decisions. Many non-upper-class working drug dependents serviced by employee assistance programs are also likely to go unreported, further contributing to an incomplete picture of the parameters of illegal drug use that underestimates upper-class and working users.

Upper-income users may find it easier to get drugs from physicians, and powerful people could have access that is not possible for others. Narcotics Commissioner Harry J. Anslinger, the leading foe of narcotics

maintenance, secretly authorized the use of maintenance for specific persons on a number of occasions. Thus, in the 1950s he maintained influential United States Senator Joseph R. McCarthy, who was a political ally, on morphine for years (McWilliams 1986).

Field Studies of Street Addicts

A number of ethnographic and other field investigations of street addicts have looked at the career of the user and noted that it requires the kind of commitment that characterizes a demanding occupation, in which only some can succeed. Several reports described the street careers of the "cool cats," "stand-up cats," and "righteous dope fiends," for whom drug use provided vocational status and achievement (Finestone 1957; Sutter 1966; Feldman 1968; Huling 1985). Considering the dismal life choices confronting a youthful ghetto male, one research team noted, his most intelligent option might be to develop a drug career (Chein et al. 1964).

Several studies argue that, even though street addicts are not doing legitimate work, their activities can be assessed in terms of criteria of successful functioning. Anthropologist Edward Preble reported that young heroin addicts in New York City gangs worked very hard at "taking care of business," following a demanding daily routine seven days per week. They had to be energetic, flexible, resourceful, and alert achievers in order to carry out their exciting and challenging tasks (Preble and Casey 1969). Street addicts are often viewed by their peers as people with very demanding jobs who are models of vocational success (Hughes et al. 1971). Other reports have documented how the addict's hustling requires harder work than conventional jobs (Gould et al. 1974).

A large-scale natural history study of street addicts (N = 238) in Baltimore involved retrospective interviews about their first ten years of addiction (Nurco, Cisin, and Balter 1981 a, b, c). Thirty-one percent never had a nonaddiction period. Among black addicts, the most frequent pattern involved uninterrupted addiction and generalized social competence. These users tended to be in control of their destiny, to avoid jail, and to be able to manage their addiction. Blacks were apt to be more successful than whites in coping and achieving fulfillment of their goals.

Studies of Work and Drug Taking in Other Societies

Studies in different societies, both economically advanced and underdeveloped, and involving a range of substances, have documented the use of habituating drugs by persons who are effective workers.

An investigation in Thailand found that some hill tribes reported that opium enabled them to function and it was not unusual to see a villager who had been addicted for 30 to 40 years and was still working actively (Suwanhala et al. 1978).

In Jamaica, where ganja plays a significant role in social and economic life, the drug often facilitates the accomplishment of work by individuals and groups. Dreher (1982) reported that its users generally feel that ganja enhances their ability to work by promoting strength and stamina. Supervisors agreed that the ganja helps workers in the arduous job of reaping sugar cane.

Dutch cocaine users not only used it while functioning effectively on the job, but typically worked while under the influence (Cohen 1989). American observers at national meetings of the Dutch "junky union" have been surprised at seeing members injecting heroin and then chairing the meetings with facility and skill.

A report by a British investigator concluded that a substantial proportion of the addicts receiving heroin at English clinics in the late 1960s could be characterized as stable, with high employment, legitimate income, and no hustling (Stimson 1973).

Federal Government's Opposition to Drugs for Addicts

What can account for the fact that a considerable body of research on the capacity of those who use drugs to work and fulfill their other social obligations has received so little attention in the shaping of public policy? What accounts for the hegemony of the perspective that only abstinence is compatible with normal functioning? Central to an understanding of this situation is the role of federal narcotics officials in shaping both public policy and the dominant social ideology.

Harry J. Anslinger, who directed the Bureau of Narcotics from 1930 to 1962, was the chief federal spokesman for the view that drug use in-

evitably produced dysfunction and pathology. Anslinger's strong views against drug maintenance were linked with his belief that addicts would typically come to the attention of the authorities in two years, so that there could be no "hidden" addicts. Federal authorities opposed efforts to provide drugs to users through the medical system and repressed information suggesting that medically maintained addicts could meet their social responsibilities.

Under Anslinger's guidance, the federal government systematically sought to distort the nature of heroin policy in England, especially through the 1960s when heroin was freely prescribed by physicians there. The British system had been described carefully in a number of publications, including a book by Schur (1962), an American sociologist. However, the Bureau of Narcotics consistently maintained that the system in England was equivalent to that in the United States. At the 1962 White House conference on addiction policy, a keynote speaker gave a lengthy speech on similarities of the British and American systems. Schur was given two minutes at the end of a session to present his contrary, and more accurate, perspective.

The FBN actively discredited scholars who expressed contrary views, such as sociologist Alfred R. Lindesmith, who taught at Indiana University and argued that drug maintenance was a possible option. When Lindesmith wrote the preface for the Indiana University Press publication of the American Bar Association–American Medical Association (1959) report suggesting some form of maintenance treatment for addicts, the bureau sent an agent to Bloomington to investigate the Press. Agents subsequently visited university officials to denounce Lindesmith (1965). On other occasions, federal agents placed him under extended surveillance and planted narcotics in his home.

The FBN published its own critique of the ABA–AMA report (Bureau of Narcotics 1959). The bureau's criticism has been described by one scholar as "the crudest publication yet produced by a government agency . . . [reflecting] the fury of the bureau's anti-intellectualism . . . [and] propaganda that panders to provincial superstition of 'un-American' types" (DeMott 1962).

As part of the federal government's campaign to discredit programs of drug maintenance, considerable misinformation was disseminated about the 44 narcotic-dispensing clinics that were in existence between 1919 and 1923 (Bureau of Narcotics 1953).

When methadone maintenance emerged as a method for treating

heroin addicts in the 1960s, it was actively opposed by the FBN. The bureau infiltrated clinics, stole records, spread false rumors, and encouraged attacks on the programs (Dole 1989). Marie Nyswander, who together with Vincent Dole pioneered the use of methadone maintenance, was under federal surveillance for years.

President Nixon, whose funding initiatives expanded methadone maintenance, never publicly identified himself with the modality and repeatedly rejected aides' insistence that he visit a methadone treatment program (Epstein 1977). Considering the climate of opinion, it is extraordinary that methadone became the dominant form of treatment for heroin addiction.

The Climate of Opinion

There was little interest in or support for heterodox views either of the relationship of drug dependence to social functioning or of drug policy until recently. The leading universities were not interested in drug dependence as a subject for teaching, research, or policy examination. There were no advocacy groups capable of challenging the orthodoxy and thereby serving as an alternative source of data for the media.

Before the National Institute on Drug Abuse was established in 1973, the NIMH provided policy guidance and leadership on matters of prevention of drug dependence and treatment of addicts. NIMH staff tended to express the traditional psychiatric view of drug users as deviants, for whom enforced abstention represented the primary treatment goal.

Contributing to the absence of discussion of alternative approaches to drug use was the dearth of prominent Americans who were willing to be identified as drug dependents. There was no lack of astronauts, generals, Nobel Prize winning writers, corporate executives, Academy Award winning actors, and other prominent Americans willing to be known as alcoholics, but entertainers and athletes are the only achievers who have borne witness to their drug use. Indeed, creation of the National Institute on Alcohol Abuse and Alcoholism in 1971 was in part the result of the efforts of two senators who publicly identified themselves as alcoholics. Very few national political leaders have been willing to become spokespersons for drug policy reform. President Carter was unable to get support for liberalizing marijuana laws and his drug policy adviser was

forced to resign. The United States had no equivalent to writers like Graham Greene and Jean Cocteau, who ascribed their creativity, to some extent, to opium use.

Despite the heavy weight of both political and intellectual orthodoxy, there was a significant effort in the mid-1960s to reshape conceptualization of the drug problem. Propounded by a small group of sociologists, this dissenting perspective sought to present drug taking as a "victimless crime" (Schur 1965). Along with gambling, pornography, prostitution, homosexuality, and abortion, drug use was portrayed as an activity that should not be the subject of legal proscriptions because it involved willing associates. This challenge, which received support from a number of quarters, has had some impact on those committed to policy reform. Whatever decriminalization, however, either de facto or de jure, has occurred for some "victimless crimes" has not been extended to drug use.

Distinguished legal scholars and activists similarly had little impact on policy. Morris Ploscowe and Rufus King were nationally prominent attorneys who challenged America's approach to drugs. Ploscowe, a former New York City judge, was the staff director for the ABA–AMA report. King (1972), who chaired the ABA committee on narcotics, subtitled his book on America's drug problem "America's Fifty Year Folly."

In this climate of opinion, the recommendation by the conservative Commission on Marijuana and Drug Abuse (1973) that marijuana be decriminalized was completely rejected by Richard Nixon, although commission chairman, Raymond P. Schafer, was a close political ally of the president.

There were others who challenged prevailing views. Some were widely discussed, like Thomas Szasz (1979), the heterodox psychiatrist who portrayed drug users as victims of the mental health movement. Other writers included Andrew Weil (1972), who urged the recognition of a right to an altered state of consciousness, and several critics with a Marxist perspective (Yurick 1970; Karmen 1973; Helmer 1975). Dissenters also called for debureaucratizing treatment (Regush 1971), community control of drug prevention (Hartjen and Quinney 1970), and a critical examination of the official epidemiology on drug use (Epstein 1977).

However, these challenges had little impact on policy because of the political power of the prevailing ideology on "dope fiends" and the portrayal of drug use as a national threat requiring a "war on drugs" by President Nixon in 1971, President Ford in 1976, and President Reagan in 1982 and 1986. Given this climate of opinion, it is not surprising

that scholars with heterodox hypotheses to examine could receive little support for their work from the preeminent source of research funds—the federal government.

Few established journals ran articles on drug dependence. A 1972 anthology that was representative of current thinking on drug use and social policy did not include even one contribution from a mainstream public health, medical, psychology, or sociology journal among its 42 articles (Susman 1972).

Until the advent of the recent reform movement, only one mainstream journal carried, in a 1957 issue, a varied and representative collection of views on American drug policy: *Law and Contemporary Problems*, the interdisciplinary quarterly published by the Duke University School of Law, each issue of which is devoted to a significant social problem (Shimm 1957). The nine contributors included key spokesmen for every significant approach to drug policy and the issue remains an important resource.

The first two American journals devoted to drug dependence were also, for some years, alone in being consistently open to a range of critical views: the *International Journal of the Addictions* (first published in 1965) and the *Journal of Drug Issues* (which began publication in 1970). Among the factors contributing to the journals' perspective has been the independence of each of its founding editors, an independence probably facilitated by the absence of institutional constraints.

Challenges to the prevailing ideology also came from the leading organization of persons interested in the drug problem, which was committed to open discussion of drug policies, the now defunct Student Association for the Study of Hallucinogens (STASH), in Beloit, Wisconsin. Controlled by students, STASH's program of publications, including books and the *Journal of Psychedelic Drugs* (in cooperation with the Haight-Ashbury Free Clinic), had considerable impact, especially on young people, in the late 1960s and 1970s.

The ferment of the 1960s, which brought into question the full range of American social institutions, provided a brief opening for fresh thinking about drug policy. The Ford Foundation, among other groups, underwrote the Drug Abuse Council (1972), which maintained a resource center, trained resident fellows, commented on policy, and funded papers and studies. After NIDA was established, the foundations felt that there was less need for the council and terminated their support.

AIDS and Functional Users

Any consideration of the functioning of drug users must address the realities of the AIDS epidemic. A substantial proportion of the drug injectors in parts of the United States will die from AIDS and many of their spouses or other sex partners will become infected.

In terms of our analysis, it would be necessary to examine the extent to which functional drug users adopt safer sex and injection practices, making them less likely to become infected. Such data are not yet available.

A variety of nongovernmental responses to AIDS could affect drug policies by identifying additional techniques for rendering the consequences of drug use less problematic. Such developments, including the spread of needle exchanges, the emergence of harm reduction as a viable goal, and vigorous community action may provide new perspectives on the characteristics of functional users.

Substance Abuse and the Functioning User

There is an analogy between the prevailing perspective on the use of heroin, cocaine, and other mood-modifying substances and the characterization of the course followed by heavy drinkers. In the case of the latter, it is typically assumed that a process of deterioration must occur (Jellinek 1952). However, deterioration is not inevitable. On the contrary, there is considerable evidence that heavy drinkers may function effectively, and that some addiction-level drinkers—a notable example being Winston Churchill—are leaders in culture, politics, and business. A number of American college graduates who averaged four drinks of whiskey, or six ounces daily, experienced no problems for a period of over 20 years (Vaillant 1983). In countries like France and Portugal, there is little relationship between heavy drinking and social distress.

Many of the daily users of alcohol and other drugs will "mature out" or otherwise stop using (Winick 1962; Maddux and Desmond 1980; Biernacki 1986; Edwards 1989). Public policy is predicated on assumptions that essentially ignore the large number of regular substance users

who terminate drug use, just as it does not acknowledge the functioning user.

Findings from the study of heroin use by military personnel in Vietnam underscored the importance of the situational element in drug taking and the reversibility of addiction (Robins et al. 1980). A major follow-up study of Vietnam veterans, 10 to 15 years after discharge, concluded that the former heroin addicts were no more likely than other soldiers to be current drug users or otherwise to reflect enduring consequences of the experience (Roth 1986). The repeated drug use of the subjects studied by Zinberg (1984) typically did not involve escalation of dosage or the loss of conventional relationships with family and nonusers. Crucial to the pattern of controlled use was the adoption of rituals that defined the appropriate time and setting of use.

Even smoking crack can be normalized and routinized. A visitor to a Harlem crack house found that most of the smokers were in their thirties and forties and had been using crack for more than five years on a regular basis (Treaster 1991). Many clearly had the capacity to control use and had remained nonaddicted. An investigation of crack-using mothers has challenged some media stereotypes (Rosenbaum et al. 1990). The majority of the respondents reported that crack actually reduced their desire to have sex. The mothers shared basic American parenting values and expressed a great deal of concern for their children. Although tough, the mothers did not physically abuse their children. Crack did tend, however, to exacerbate already difficult socioeconomic living conditions. It was such underlying conditions, rather than crack use, that most effectively explained the extent to which such women departed from conventional norms of behavior.

In large measure, assumptions about the inevitability of the rapid onset of addiction with crack use is based on observations about the dominant mode of ingestion—smoking. There is some evidence, however, that when ingested differently, crack use may be less problematic. In one study by Siegel (1989, 308–11), over 200 California patients sniffed cocaine freebase ("Esterene"), or crack, under medical supervision, for the relief of arthritis, for more than two years without a single case of abuse. Some patients took 750 milligrams daily with no ill effects. Used intranasally, the crack was absorbed very slowly by the nostril's mucous membranes—the nose functioned like a time-release capsule. The program was halted by the state. However, 175 other persons in the Los Angeles area were found who were using intranasal cocaine freebase,

outside of medical supervision. Few were experiencing problems, even with daily doses of 1000 milligrams. Their regular use without severe dysfunction suggested the possibility of safe use in nonmedical settings.

A largely middle-class population (N = 267) of heavy cocaine users was generally able to avoid experiencing major disruptions or significant distress in their lives (Waldorf, Reinarman, and Murphy 1991). Most who wanted to stop using were able to do so on their own and found that quitting was less difficult than had been expected. Cocaine use was neither immediately nor inevitably addictive, and controlled use was extremely common. Interaction with jobs, family, and friends helped to minimize problems. Many formerly heavy users were able to resume occasional use without relapse.

Conclusions

In any population of drug users, there will be some who can regulate their habit. Even the most intoxicating and addictive substances can be, and often are, used safely. Many of the negative consequences of drug taking may reasonably be attributed to preexisting problems of users or the interaction between their disadvantaged status and current policies regulating the price and availability of drugs.

Almost all the cocaine dealers described by Williams (1989) used cocaine, but most of the successful dealers did so in moderation whereas the least successful allowed themselves to become compulsive users. Reanalysis of the data from such studies could provide significant clues to the personal and social circumstances, factors, and variables that could explain the relative likelihood of either functional and dysfunctional consequences of psychoactive drug use.

However, with daily evidence of widespread negative consequences from addiction and nonmedical psychoactive drug use, it would be totally misleading to convey the impression that the use of psychoactive drugs holds no hazards. It is important, however, to note that the risks of taking such drugs are often overestimated because American society as a whole has rejected nonmedical drug use for almost a century.

A Calvinistic pharmacology prevails even in the medical use of drugs. A pattern of "opiophobia" (Morgan 1989)—manifested in the customary underprescription by clinicians of analgesics to postoperative patients—exists because of concerns about addiction. The Public Health

Service is contemplating phasing out its program that permits a small number of patients (Hecht 1991) to smoke marijuana for relieving the nausea and vomiting that accompany some diseases and treatments, for reducing spasticity and pain in multiple sclerosis, and for easing intraocular pressure from glaucoma (Morgan and Zimmer 1991). Instead it proposes to substitute a synthetic form of marijuana containing a substance that prevents patients from getting high despite the belief by some that the substitute will be less effective (Siegel 1989, 312–13).

In this article I have provided evidence indicating that some people can regularly use drugs without harming themselves or inflicting losses on others. However, we do not currently know the probability of this outcome as opposed to more disastrous scenarios. We do not know how those whose lives have become profoundly disrupted by drug use differ from those for whom it poses no such difficulty. Most important, we do not know the relative impact of current prohibitionist policies on the patterns of dysfunctional drug use.

Other cultures provide clues that, without repressive laws, adult users may be able to regulate their own behavior and decide for themselves what constitutes appropriate use. The Dutch study of cocaine users, for example, demonstrated that a significant proportion of the sample experienced periods of increasing use (Cohen 1989). For others, cocaine use became so problematic that they abstained, either for long periods of time or entirely. So long as our government policy is based upon the assumption that nonmedical drug use is destructive, we cannot develop substantial knowledge of the factors that enhance such effective self-regulation of use.

In the case of alcohol and other drugs, former users help to define much of the discourse about drug policy. Like government officials, many feel a vested interest in extending their perception that psychoactive substance use is inherently dysfunctional. These expressions reinforce the dominant ideology, effectively ensuring little flexibility of outlook in American policy.

A more humane drug policy, grounded in a less distorted understanding of the existing patterns of drug use, would be more tolerant of benign drug use and would seek to prevent or control adverse consequences through appropriately fashioned public policy. The recent emergence of organizations committed to exploring policy alternatives, like the Drug Policy Foundation (founded in 1987), journals like the *In-*

ternational Journal for Drug Policy (launched in 1989), and annual international meetings on the strategy of harm reduction (first held in 1990) suggest that the issue of nonharmful drug use could become more salient in the future. It is just possible that the prohibitionist ethos may loosen its hegemony, thus opening the way for the first time in almost a century for a fundamental rethinking of the issue of drug use.

References

American Bar Association and American Medical Association. 1959. *Drug Addiction: Crime or Disease?* Bloomington: Indiana University Press.

Anglin, M.D., Y. Hser, M. Booth, et al. 1988. *The Natural History of Narcotic Addiction*. Los Angeles: University of California.

Anthony, J.C., C.J. Ritter, M.R. Von Korff, et al. 1985. Descriptive Epidemiology of Adult Cocaine Use in Four U.S. Communities. In *Proceedings of the 47th Annual Scientific Meeting of the Committee on Problems of Drug Dependence*, ed. L.S. Harris, 283–9. Rockville, Md.: National Institute on Drug Abuse.

Biernacki, P. 1986. *Pathways from Heroin Addiction: Recovery without Treatment.* Philadelphia: Temple University Press.

Bureau of Narcotics, U.S. Treasury Department. 1953. *Narcotics Clinics in the United States.* Washington.

———1959. *Comments on Narcotics Drugs: Interim Report of the Joint Committee of the American Bar Association and the American Medical Association*. Washington.

Capel, W.C., B.M. Goldsmith, K.J. Waddell, et al. 1972. The Aging Narcotic Addict: An Increasing Problem for the Next Decades. *Journal of Gerontology* 27:102–6.

Caplovitz, D. 1976. *The Working Addict.* White Plains, N.Y.: Sharpe.

Chein, I., D.L. Gerard, R.S. Lee, and E. Rosenfeld. 1964. *The Road to H.* New York: Basic Books.

Cohen, P. 1989. *Cocaine Use in Amsterdam in Nondeviant Subcultures.* Amsterdam: Institut voor Sociale Geografie, Universiteit van Amsterdam.

Commission on Marijuana and Drug Abuse. 1973. *Final Report.* Washington.

Cutting, W.C. 1942. Morphine Addiction for 62 Years. *Stanford Medical Bulletin* 1:39–41.

Dai, B. 1937. *Opium Addiction in Chicago*. Shanghai: Commercial Press. (Reprinted by Patterson Smith in 1970.)

DeMott, B. 1962. The Great Narcotics Muddle. *Harper's Magazine* 224:46–54.

Dole, V. 1989. Interview. In *Addicts Who Survived: An Oral History of Narcotics Use in America, 1923–1965*, ed. D. Courtwright, H. Joseph, and D. Des Jarlais, 331–43. Knoxville: University of Tennessee Press.

Dreher, M.C. 1982. *Working Men and Ganja: Marijuana Use in Rural Jamaica.* Philadelphia: Institute for the Study of Human Issues.

Drug Abuse Council. 1972. *Dealing With Drug Abuse: A Report to the Ford Foundation.* New York: Praeger.

Edwards, G. 1989. As the Years Go Rolling By: Drinking Problems in the Time Dimension. *British Journal of Psychiatry* 154:18–26.

Ellis, R., and R.C. Stephens. 1976. The Arrest History of Narcotic Addicts Prior to Admission: A Methodological Note. *Drug Forum* 5:211–24.

Epstein, E.J. 1977. *Agency of Fear.* New York: Putnam.

Feldman, H.W. 1968. Ideological Supports to Becoming and Remaining a Heroin Addict. *Journal of Health and Social Behavior* 9:131–9.

Finestone, H. 1937. Cats, Kicks and Color. *Social Problems* 5:3–13.

Frank, B., R. Marel, J. Schmeidler, et al. 1984. An Overview of Substance Use among New York State's Upper Income Householders. *Advances in Alcohol and Substance Abuse* 4:14–26.

Gould, L.C., A.C. Walker, L.E. Crane, and C.W. Lidz. 1974. *Connections: Notes from the Heroin World.* New Haven: Yale University Press.

Graeven, D.B., and K.A. Graeven. 1983. Treated and Untreated Addicts: Factors Associated with Participating in Treatment and Cessation of Heroin Use. *Journal of Drug Issues* 13:207–18.

Haden-Guest, A. 1983. Rich Kids on Smack: The Young, The Rich, and Heroin. *Rolling Stone* 399 (July 7):26–7.

Hanson, B., G. Beschner, J.M. Walters, and E. Bovelle. 1985. *Life with Heroin: Voices from the Inner City.* Lexington, Mass.: Lexington Books.

Hartjen, C.A., and R. Quinney. 1970. The Social Reality of the Drug Problem: New York City's Lower East Side. *Human Organization* 30:381–91.

Hecht, B. 1991. Out of Joint: The Case for Medicinal Marijuana. *New Republic* (July 15):7–10.

Helmer, J. 1975. *Drugs and Minority Oppression.* New York: Seabury Press.

Hendin, H., A.P. Haas, P. Singer, M. Ellner, and R. Ulman. 1987. *Living High: Daily Marijuana Use among Adults.* New York: Human Sciences Press.

Hughes, P., G.A. Crawford, N.W. Barker, S. Schuman, and J.H. Jaffe. 1971. The Social Structure of a Heroin Copping Community. *American Journal of Psychiatry* 1971, 128:551–8.

Huling, M. 1985. A Professional's View of Drug Abuse. In *Junkies and Straights: The Camarillo Experience*, ed. R.H. Coombs, 21–56. Lexington, Mass.: Lexington Books.

Ingle, J.I. 1971. William Halsted, Surgeon, Pioneer in Oral Nerve Block Injection and Victim of Drug Experimentation. *Journal of the American Dental Association* 82:46–7.

Jellinek, E.M. 1952. Phases of Alcohol Addiction. *Quarterly Journal of Studies on Alcohol* 13:673–84.

Karmen, A. 1973. The Drug Abuse–Crime Syndrome: A Radical Critique. In *Sociological Aspects of Drug Dependence*, ed. C. Winick, 309–19. Cleveland: CRC Press.

King, R. 1972. *The Drug Hang-up: America's Fifty Year Folly.* New York: W.W. Norton.

Kolb, L. 1928. Drug Addiction—A Study of Some Medical Cases. *Archives of Neurology and Psychiatry* 20:171–83.

Lindesmith, A.R. 1965. *The Addict and the Law*, 243–68. Bloomington: Indiana University Press.

Maddux, J.F., and D.P. Desmond. 1980. New Light on the Maturing Out Hypothesis in Opioid Dependence. *Bulletin on Narcotics* 32:15–25.

———. 1981. *Careers of Opioid Users.* New York: Praeger.

McWilliams, J.C. 1986. *The Protectors: Harry J. Anslinger and the Federal Bureau of Narcotics 1930–1962*, 177–9. Ph.D. dissertation, Pennsylvania State University.

Michaels, R.J. 1987. The Market for Heroin Before and After Legalization. In *Dealing With Drugs: Consequences of Government Control*, ed. R. Hamowy, 327–52. Lexington, Mass.: D.C. Heath.

Morgan, J. 1989. American Opiophobia: Customary Underutilization of Opioid Analgesics. In *Advances in Pain Research and Therapy*, vol. 2, eds. C.S. Hill, Jr., and W.S. Fields, 163–73. New York: Raven Press.

Morgan, J., and L. Zimmer. 1991. U.S. Needs a Dose of Compassion. *New York Newsday* (August 28):91.

Morhous, E.J. 1953. Drug Addiction in Upper Economic Levels: A Study of 142 Cases. *West Virginia Medical Journal* 49:189–90.

Nurco, D.N., I.H. Cisin, and M.B. Balter. 1981a. Addict Careers. I. A New Typology. *International Journal of the Addictions* 16:1305–25.

———. 1981b. Addict Careers. II. The First Ten Years. *International Journal of the Addictions* 16:1327–56.

———. 1981c. Addict Careers. III. Trends Across Time. *International Journal of the Addictions* 16:1357–72.

O'Donnell, J. 1969. *Narcotic Addicts in Kentucky.* Chevy Chase, Md.: National Institute of Mental Health.

O'Donnell, J.A., H.L. Voss, R.R. Clayton, et al. 1976. *Young Men and Drugs—A Nationwide Survey.* Washington: National Institute on Drug Abuse.

Penfield, W. 1969. Halsted of Johns Hopkins, the Man and His Problem as Described in the Secret Records of William Osler. *Journal of the American Medical Association* 210:2214–17.

Preble, E., and J.J. Casey. 1969. Taking Care of Business. *International Journal of the Addictions* 4:1–24.

Regush, N.M. 1971. *The Drug Addiction Business.* New York: Dial Press.

Robins, L.N. 1974. *The Vietnam Drug User Returns.* Special Action Office Monograph series A, no. 2. Washington.

Robins, L.N., J.E. Helzer, M. Hesselbrock, and E. Wish. 1980. Vietnam Veterans Three Years After Vietnam: How Our Study Changed Our View of Heroin. In *Yearbook of Substance Use and Abuse*, vol. 2, eds. L. Brill and C. Winick, 213–30. New York: Human Sciences Press.

Rosenbaum, M., S. Murphy, J. Irwin, and L. Watson. 1990. Women and Crack: What's the Real Story? *The Drug Policy Letter* 2:2–4.

Roth, L.M. 1986. Substance Use and Mental Health among Vietnam Veterans. In *The Vietnam Veteran Redefined: Fact and Fiction*, ed. G. Boulanger and C. Kadushin, 61–77. Hillsdale, N.J.: Lawrence Erlbaum.

Rounsaville, B.J., and H.D. Kleber. 1985. Untreated Opiate Adults: How Do They Differ from Those Seeking Treatment? *Archives of General Psychiatry* 42:1072–77.

Schur, E.M. 1962. *Narcotic Addiction in Britain and America: The Impact of Public Policy.* Bloomington: Indiana University Press.

———. 1965. *Crimes Without Victims.* Englewood Cliffs, N.J.: Prentice-Hall.

Shimm, M.G. Ed. 1957. Narcotics. *Law and Contemporary Problems* 22 (winter).

Siegel, R.K. 1989. *Intoxication: Life in Pursuit of Artificial Paradise.* New York: E.P. Dutton.

Stimson, G.V. 1973. *Heroin and Behavior.* New York: Wiley.

Susman, J. Ed. 1972. *Drug Use and Social Policy.* New York: AMS Press.

Sutter, A.G. 1966. The World of the Righteous Dope Fiend. *Issues in Criminology* 2:177–222.

Suwanhala, C., V. Poshyachinda, P. Tasanapradit, and A. Dharmkrong-at. 1978. The Hill Tribes of Thailand: Their Opium Use and Addiction. *Bulletin on Narcotics* 30:1–19.

Szasz, T. 1979. *Ceremonial Chemistry: The Ritual Persecution of Drug Addicts and Pushers.* London: Routledge and Kegan Paul.

Talbott, G.D., and C. Wright. 1987. Chemical Dependency in Health Care Professionals. *Occupational Medicine State of the Art Review* 2:581–91.

Treaster, J.B. 1991. In a Crack House: Dinner and Drugs on the Stove. *The New York Times* (April 6):24.

Vaillant, G.E. 1983. *Natural History of Alcoholism.* Cambridge, Mass.: Harvard University Press.

Waldorf, D., C. Reinarman, and S. Murphy. 1991. *Cocaine Changes: The Experience of Using and Quitting.* Philadelphia: Temple University Press.

Waldron, S. 1969. Statement to Select Committee on Crime, House of Representatives, 91st Congress, July 29.

Weil, A. 1972. *The Natural Mind.* Boston: Houghton Mifflin.

Williams, T. 1989. *The Cocaine Kids: The Inside Story of a Teenage Drug Ring.* Reading, Mass.: Addison-Wesley.

Winick, C. 1960. The Use of Drugs by Jazz Musicians. *Social Problems* 7:240–53.

———. 1962. Maturing Out of Narcotic Addiction. *Bulletin on Narcotics* 16:1–11.

———. 1990. Substance Dependence among Physicians and Nurses. In *The Sociocultural Matrix of Alcohol and Drug Use*, eds. B. Forster and J.C. Salloway, 342–66. Lewiston, Maine: Edwin Mellen Press.

———. 1992. A Ten Year Follow-Up of Working Opiate Users. *Journal of Addictive Diseases.* (Forthcoming.)

Yurick, S. 1970. The Political Economy of Junk. *Monthly Review* 22:22–35.

Zinberg, N.E. 1984. *Drug, Set and Setting.* New Haven: Yale University Press.

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