Historical Perspectives on Community Controls of AOD-related Problems

A Brief Overview

Problems with alcohol, tobacco, and other drugs have been a major concern of U.S. society since the earliest Colonial times. Our current prevention policies and practices are built on concepts and strategies that have been built up over 300 years.

As major changes have occurred from one historical period to the next, AOD problems reappear in the changing social and economic conditions of the times. Community efforts to overcome AOD problems in each period should be understood in terms of the social and political contexts for the periods in which the problems occur.

Our particular interest is from the perspective of local community action. From colonial times to the present, local communities can ask: "What can we learn from past experience to apply to the present?" How have local communities responded to the AOD problems of their day? What guidance and help (or lack of help) have communities had from the state? How do our "new" ideas depend on earlier concepts and strategies? America's history offers a rich palette of approaches to prevention from which to learn as the experiences of one era roll forward into the next.

This chapter provides a brief historical overview of the social and political context for efforts to prevent alcohol and other drug problems in the U.S. and California. Five eras are reviewed:

1) The Colonial Era (pre-Revolutionary times to 1830);
2) The Industrial Era (1830 to 1918);
3) The Prohibition Era (1919 to 1933);
4) The Control, Treatment, and Recovery Era (1933 to the present) including the Public Health Movement and the War on Drugs.

These historical periods coincide especially with shifts in experiences regarding alcoholic beverages. Historically, until very recently, alcohol experiences have been more prominent in shaping public policy than experiences with other drugs. Alcohol has been more available and is more widely consumed than illicit drugs, and alcohol-related problems on the whole are responsible for more trouble than are problems related to illicit drugs.

Alcohol experiences have captured public attention both because alcohol is a large part of popular culture and because it has long been associated with social and economic problems. Public demand to take action on alcohol-related problems has taken different form over the years depending on alcohol's position in our culture.

Understanding the significance of alcohol-problem prevention initiatives for each major historical period involves understanding three things: (1) the significant patterns of alcohol and other drug availability and use of the day; (2) AOD problems as they were perceived at the time; and (3) community responses to reduce or prevent the problems. This format is also useful for looking at problems with illicit drugs and tobacco.
Experiences with alcohol and with illicit drugs were viewed largely independently of each other until the 1980s. Since then, concerns about illicit drugs have played increasingly greater roles in shaping society's responses to AOD problems. Illicit drug availability appeared to increase in the late 1970s and 1980s, especially in inner cities. Additionally, federal block grant programs to the states since 1980 have combined funding for prevention of problems related to alcohol and to illicit drugs. Combined funding has led to combined administration of AOD prevention programs at all three levels of government.

Contrary to the prevailing tendency, this chapter separates discussion about alcohol, tobacco and other drugs into three separate sections. The first section will be on alcohol, the second section will be on illicit drugs, and the third will be on tobacco. It makes sense to separate discussion about prevention policies and programs for alcohol -- a highly-public drug that is legally available to adults -- from prevention initiatives for covertly-consumed illicit drugs. Although some argue that currently illicit drugs should be legalized or decriminalized since they now are almost as easy to get as alcohol and tobacco, the State of California vigorously opposes legalization or decriminalization of illicit drugs. The history of prevention action on tobacco problems, not a direct responsibility of the Department of Alcohol and Drug Programs, will be reviewed briefly in the last section of this chapter.
SECTION 1: ALCOHOL

The Colonial Era (1700-1830)
The same problems and policies regarding alcohol extended throughout the Colonial period, past the Revolutionary War, and into the early days of the new republic.

Pre-Revolutionary Period (1700-1789)
The consumption of alcoholic beverages was viewed as a sociable and healthy activity in the relatively stable Colonial period. Alcohol was thought by some to be a health food. Once called "the good creature of God," from a community perspective, alcoholic beverages were considered to be an essentially benevolent substance that promoted good feeling and community spirit, and caused few problems.

Availability
Alcohol appeared primarily in the form of beer and hard cider. Nearly all alcoholic beverages were manufactured locally. Wine and spirits were relatively rare among laborers, farmers, and mechanics. Slaves and indentured servants were rarely allowed to drink. The upper classes of the day--nobility, substantial property-owners, and wealthy merchants --all drank wine and spirits.

Alcoholic beverages were an integral part of everyday community life in early Colonial America. The colonies were settled with many small towns and villages, and even the largest cities, such as Philadelphia, had clearly-defined centers and well-defined neighborhoods or districts. Taverns were usually found at the center of the town, village, or district. Roadhouses that served alcoholic beverages were located at convenient distances along highways and roads. These establishments were simultaneously places to drink, to obtain information about community activities, and to serve as sites for community meetings. Tavern-keepers were generally held in high-regard, and were often the town's leading citizens; in New England, their sons were well represented among students at Harvard. Some towns required that taverns be established in order to have places to hold community meetings.

In the agrarian culture of the 1700s, people used to drink beer during the day while they were working. Work proceeded at a leisurely pace, with frequent breaks and time off to attend to personal and family matters. People worked according to the seasons and to the cycle of the day, rather than to preset schedules. Workers knew each other well and often worked in groups, the boss often working alongside the workers. Beer and hard-cider were sometimes given as wages.

Problems and Responses
Alcohol problems were few. Since alcohol itself was viewed as healthful, and the settings for its use were well-controlled, drinking problems were viewed as problems of the individual drinker. Consumption of alcoholic beverages was tightly controlled through social conventions and through traditions of propriety; outright inebriation was frowned upon. Since people did most of their drinking together, the community's norms and conventions exerted strong preventive influences on the individual drinker.

Self-control by the individual, with reminders from neighbors, was the primary means for
prevention. Tavern patrons who drank too much were advised by the tavern-keeper to “mind their p’s and q’s,” or watch the number of pints and quarts they consumed. Those who drank too much (“drunkards”) were considered to have personal failings when they did not respond to the community’s expectations and the reminders provided by those around them. Personal failings usually were attributed to lack of character, or to moral weakness.

Post Revolutionary Period (1789-1830)
With rapid growth and expansion westward following the Revolution, alcohol’s formerly stable position in colonial society changed dramatically. Rapid increases in alcohol availability from several sources led to dramatic rises in drunkenness. Disapproval of personal drunkenness no longer sufficed as a control measure. The concept of addiction emerged, and the groundwork was laid for temperance movements.

Availability
America was still largely an agrarian society as it expanded westward toward the Mississippi. Commerce grew rapidly to link the farms of the Midwest to the growing cities in the east. The transportation of grain (corn) in the form of distilled spirits became popular as an efficient and profitable way to send produce to market. Additionally, America’s merchant fleets began active trade with Europe, the Caribbean, and Africa to move finished goods, rum, and slaves; some slave-traders used profits from transporting rum to finance trips to Africa. Alcohol flooded into U.S. seaport communities, adding strong spirits to beer and hard cider already in use. America became extremely wet; its national average per capita consumption in the 1830s, estimated at more than five gallons of pure alcohol per adult per year, was twice today’s rate.

Problems
Perspectives on alcohol shifted to include that of disabler and scourge alongside its identity as a health food and facilitator of sociability. Journals and diaries of the period tell of constant drunkenness both at work and at leisure, in public and in private, and in all sectors of community life except the churches. Rampant drunkenness among so many people made it difficult to hold each individual personally responsible for drunken behavior, and made it hard to view drunkenness only as a matter of personal moral failings. Drunkenness also came to be viewed as a matter of addiction beyond personal control; high levels of drunkenness came to be viewed as shortcomings of the community as well as the person.

Responses
Addiction and Abstinence
Benjamin Rush, social reformer, physician, and founder of asylums for the insane, was a leader among those who argued that epidemic drunkenness could be explained by addiction to alcohol. Addiction was occasioned by alcohol’s extraordinarily high levels of availability, and by norms that encouraged high levels of consumption. Rush warned against excessive consumption, counseling complete abstinence for those who lacked the discipline to moderate their drinking. The asylum offered a home, permanently or temporarily, for those who became addicted after failing to moderate their drinking appropriately. Rush’s views of addiction are still widely held, as are his observations about the environment of alcohol availability as a significant contributor to community-level alcohol problems.
Grassroots Temperance

Local communities developed a grassroots response to the wave of drinking and drunkenness that had swept the country. Coalitions of concerned local citizens -- leaders concerned about the community's welfare (especially women), certain businessmen, religious figures, and others -- met to form local temperance societies. The temperance societies supported abstinence, the removal of troublesome outlets, and public control of the sale of alcoholic beverages to minimize future problems. These local groups were soon to coalesce into a national movement.

The Industrial Era (1830-1918)

The Industrial era ushered in the urbanization of America and created a production and consumption-driven economy. Alcoholic beverages became increasingly important as commercial products to be consumed in large quantities. In addition, alcoholic beverages continued their Colonial Era meanings as gifts, rewards, and other tokens of exchange that create social bonds.

Alcohol's position in U.S. communities changed radically along with major changes in the nation's society and economy. Work and leisure became separate as the industrial era brought scheduling, compartmentalization, and regimentation into community life. Drinking on-the-job became increasingly unacceptable. Entrepreneurial activity and business cycles separated common workers, managers, and owners into different groups; the different groups began to drink in separate ways, as laborers and poor people continued to drink in public, and as managers, owners, and elites increasingly drank in private.

Several waves of immigration occurred prompted by European political unrest and agricultural disasters. American society fragmented into different social and political groups. Racism, ethnic discrimination, and fear of foreigners became fixtures of urban life. Each new community developed its own drinking styles and its own drinking settings and locations.

New social and political elites emerged, beginning with populist democracy under Andrew Jackson. Social elites from the Revolutionary era lost their power to dictate appropriate styles and circumstances for drinking. With the end of slavery following the Civil War, the formal powers of one social group to directly control the drinking of another also faded, although the use of alcohol to exploit vulnerable groups continued, particularly for Native Americans. The aftermath of the Civil War also shifted the balance of power between the states and the federal government, and led to increased state control over local affairs, particularly in the South. By the late 1800s, a number of states were regulating availability and use of alcoholic beverages.

Westward expansion opened new sources of mineral and agricultural wealth to provide vast resources for a consumer-based society. By the time the frontier was officially declared closed in 1890 and all federal territories in the west began conversion to statehood, the stage had been set for expanding widespread local production of alcoholic beverages into mass-production. Improvements in beverage production and bottling technology and in the transportation system assured the rapid shipment of alcoholic beverages to every community in the country.
Availability
Alcoholic beverage availability remained high. Breweries opened all over the country to serve local communities; distilleries flourished especially in the South. Taverns, restaurants, bars, and saloons served alcohol to everyone, at all times of day and night, both for off-sale and on-sale. For example, travelers to San Francisco in the early 1850s reported bars and saloons on all four corners of major intersections, each outlet resounding with the song and language of a different ethnic group or clientele. San Francisco's current high levels of retail alcohol outlet availability, approximately twice the state's average, reflect the high levels of availability from this period.

As restaurants, taverns and saloons flourished in different communities, they became identified with different political and social groups. In the big cities, bars and saloons became identified with machine politics. Alcohol outlets of all types also divided socially into "high-class places" to which women and families could go, and into "places of ill-repute" that became associated with gambling, prostitution, and other vice activities.

Problems
Alcohol contributed in many ways to the difficulties that accompanied the nation's rapid social change and industrialization.

Ethnic Tensions and Fear of Foreigners
Caricatures of different drinking styles were used to emphasize negative features of the differences between groups, and to create stereotypes. Street-drinking at rallies and political demonstrations led to public disturbances and riots.

Labor Practices and Class Differences
Drinking on the job continued, though it was increasingly frowned upon. Alcoholic beverages continued to serve as wages, and "free lunches" were offered to urban workers who spent their lunch hours in saloons. Drinking among poor people and laboring people tended to occur in public, "on, view" and subject to criticism; drinking among wealthy people and the emerging middle class became more private and less subject to comment.

Welfare Issues for Inebriates, Children, and Families
Little help was available for inebriates in the nation's asylums, which became increasingly overcrowded and poorly-run as the nineteenth century progressed. Children were abused and exploited through the use of alcohol. Families with alcoholic breadwinners had to depend solely on pittances from private charity and the kindness of neighbors, friends and family.

Public Order and Decorum, Vice and Corruption
Certain parts of rapidly-growing urban communities became known as places to be avoided due to drunkenness, prostitution, and violence. Rises in transiency, the use of itinerant labor, and waves of unemployment occurred due to seasonal and short-term jobs in agriculture, construction, and transportation. Manufacturing jobs, based heavily on the manual laborer, rose and fell with rises and crashes in the stock market. Starting after the Civil War, large numbers of single men began moving from city to city and from region to region to find work, giving rise to "hobo villages" on the outskirts of cities and to "skid rows" near transportation hubs and labor pools.
Many of these men were heavy drinkers and alcoholics. Attempts of local governments and citizens groups to control drinking, gambling, prostitution, and violence became contentious, subject to political influences from many parties ranging from church groups and aristocrats who wanted firm controls to local manufacturers and merchants who found the town’s drinking problems minor in comparison to the economic benefits that accompanied them.

**Exploitation of Vulnerable Groups**
Alcoholic beverages were used by unscrupulous traders, real estate developers, and public officials to exploit Native Americans, immigrant workers, and other vulnerable groups.

**The Emergence of the Saloon**
As immigration increased and cities grew, the saloon emerged as a questionable social institution in those districts characterized by poverty and high proportions of recent immigrants. Concerns about political organizing, on-view drinking, vice activities, and the free expression of different customs in foreign languages, led to identification of the saloon itself as a major source of social, political, and economic unrest.

**Responses**
Community responses to alcohol problems during the nation’s industrial age can be classified into early and late periods in the temperance movement. The early period was essentially a local social movement that consisted of the coming together of community-based grassroots initiatives which grew into a national movement. The late period consisted of political action dedicated to solving the nation’s “alcohol problem,” as it came to be called. Today many people erroneously equate both early and late periods of the temperance movement in the U.S. with the Prohibition era which followed it. In fact, the temperance movement embraced widely different views on the control of alcoholic beverage availability, including liberal approaches toward local control (which are still active today), to national-level prohibition that became policy from 1919 to 1933 (for which advocacy has essentially disappeared).

**Early Temperance (1830-1880)**
Responses to alcohol problems in the early industrial age occurred initially at the local community level. Early temperance societies of the 1830s were composed of community leaders and individuals who sought to create communities among themselves that would be free of the problems related to excessive drinking. Their first thoughts were to create a comfortable sub-community in which the immediate members of their society could live free of the troubles created by excessive drinking. Initially, they pledged to each other that they would drink moderately or not at all, and that they would encourage their friends and neighbors to do likewise.

“High” and “Low” Temperance
Debate among friends soon warmed to disagreement over the best ways to advance temperance ideals at the community level. Local temperance societies diverged over the best course for public policy to follow, clashing over “high” temperance and “low” temperance. High temperance emphasized strict standards of personal behavior—absolute abstinence, morality, rectitude. High-temperance advocates viewed alcohol
itself as inherently problematic, both because of its psychoactive properties and because of its negative associations with community problems. High-temperance advocates sought to ban alcohol entirely, at least from their own lives and preferably from the whole community. ‘T-totallers’ were people who pledged total abstinence as part of a personal commitment to live a highly-disciplined, morally-correct life.

Low temperance advocates emphasized civil order and domestic peace. They were not so concerned about drinking per se or the details of personal conduct, as they were about the control of excessive drinking and problematic behaviors among neighbors and in the larger community. Advocates of low temperance did not mind drinking per se, which they realized many people did without trouble, but they objected very much to settings and circumstances in which drinking became problematic.

**From Alcohol Problems to Social Issues and Public Policy**
Temperance advocates from both camps did not confine their thinking simply to alcohol-related problems. The advocates also tended to be the liberal thinkers of their day, concerned about social issues and social improvements, and about better government.

Temperance advocates recognized close connections between alcohol problems and other social issues, and were likely to be active on several fronts. Temperance advocates were also concerned about issues of slavery, about integration of new immigrants into American society, about the status of women, and about public health and welfare. Temperance supporters concerned about these other issues recognized their interaction between alcohol, and saw that prevention efforts might do double duty to help solve both sets of problems.

The early temperance movement moved beyond personal temperance and the asylum to embrace public policy as a vehicle for community-level prevention initiatives. Both high- and low-temperance advocates moved in this direction. Initially, temperance movement followers gave little thought to modifying larger social and economic patterns that produced alcohol-related problems in so many communities. However, as government expanded its roles in dealing with social problems -- for example, as Congress, the Supreme Court, and the state legislatures tackled issues of slavery, immigration, and expansion of the frontier--temperance advocates became increasingly active in viewing “the alcohol problem” as a matter for legislation and public policy at all three levels of government.

**Late Temperance (1880-1918)**
As industrial expansion continued and as the population increased, especially through high levels of immigration from 1880 on, concerns about alcohol-related problems continued to grow. Sale and consumption of alcohol were by now closely identified with the nation’s social and economic problems. The temperance movement became heavily involved with public policy at both local and national levels. Temperance advocates from both "high" and "low" wings of the movement pursued both moral and practical approaches.

**Moral Reform**
Many temperance advocates appealed for abstinence and for the closing of saloons,
breweries, and other sources of supply wherever possible. Their campaign techniques included sermons, mass demonstrations, prayer vigils, educational activities and pamphleteering, and voluntary negotiations with saloon keepers and local officials. The advocates often knew they would not get all they asked for, but they persisted anyway to make broader points about the need to protect basic American values and to urge elected officials and others with power to act properly. Often the moralists would win partial victories, and would gain sympathizers, even if they did not succeed in gaining support for complete abstinence.

Practical Reforms: Early Local and State Controls
Advocates of practical controls on alcohol sought a variety of legislative remedies at both local and state levels. Efforts to establish controls at local levels were minimally effective since local jurisdictions had only limited powers to impose definitive local controls over alcohol outlets during the height of the temperance era. Strong local zoning and land-use law would not be available to communities in the U.S. until 1926. In the meantime, local controls were very difficult to implement both politically and practically. For example, cities often fell to arguing over "high license" and "low license" controls. "High license" meant charging higher license fees, encouraging only better-run alcohol establishments to do business in the community. However, charging a high license fee might also encourage "blind pigs," secret unlicensed outlets winked at by easily-bribed officials.

Problems in establishing regulations at the local level drove reformers to seek state legislation to control the sale of alcohol. Here they were often successful, in some cases securing easy passage for restrictive legislation to limit drinking in public, to forbid the sale of alcohol to minors or near college campuses, to disallow the sale of alcohol on Sunday, and to require that wages not be paid in alcoholic beverages.

"Broad-gauge" vs. "Narrow-gauge "Control Strategies: The Triumph of Narrow-gauge Prohibitionists
The temperance movement agreed on the need for public policy to control problems related to alcohol, but divided on whether to pursue "broad gauge" or "narrow gauge" approaches. Broad-gaugers saw alcohol problems as symptomatic (symbolic) of economic and social problems which required attention from progressive governments dedicated to meeting the needs of the public, particularly laborers, immigrants, and the needy. Their recommendations sought to respond to alcohol-related problems by attacking underlying social injustices and economic inequalities.

Narrow-gaugers saw problems with alcohol as their sole concern. They believed that many of the nation’s problems could be solved simply by restricting or prohibiting the sale of alcohol. The prohibitionists among the narrow-gaugers gained the upper hand by creating a surprisingly-successful political strategy to secure state-by-state prohibition through legislative activity and political campaigning.

The Anti-Saloon League
The Anti-Saloon League was the prohibitionist’s political organization. The League became active in local and state elections, undertaking organizing and coalition building in local communities throughout the country. The League caught on quickly to the idea of creating a strong political base to reach its social objectives. From its solid
political base in the church community and other welfare-oriented groups, narrow-gaugers discovered block-voting and "single-issue" political campaigning. Contestants for political office quickly added prohibition planks to their platforms when confronted with a sizeable group of their constituents who would not vote for them otherwise.

An astonishing number of political victories at the state level led the narrow-gauge prohibition advocates to press for adoption of national prohibition by Congress in 1918. National Prohibition was adopted in the face of high levels of support through state elections and a vigorous national campaign directed both at the general public and at Congressional representatives. In the political climate of snowballing support, little time was taken to define exactly what “national prohibition” meant. Definition was left to the Volstead Act of 1919, passed to implement the Constitution’s 18th Amendment.

**The Prohibition Era (1919-1933)**

Although it was in effect barely fourteen years, Prohibition profoundly affected public perceptions and public policy regarding the prevention of alcohol-related problems. Prohibition demonstrated both the need for preventive controls on legally-available alcoholic beverages, and the high levels of controversy and resistance associated with them. Prohibition also demonstrated the preventive effects of restricted availability on alcoholism and alcohol-related diseases.

Prohibition took effect during the “Roaring Twenties,” a period of social experimentation and unchecked economic growth. Initial popular support for Prohibition soon gave way to widespread lawbreaking by manufacturers and suppliers of alcoholic beverages (purchasing alcohol was not a crime under Prohibition, but manufacturing and distribution was). Popular support evaporated over concerns about lawlessness and the accompanying crime and violence. Public agencies lamented the loss of tax revenues; before Prohibition, alcohol taxes had been the largest single source of federal revenue.

The "Noble Experiment" was, according to many observers, badly flawed in its administration. Federal administration of the Volstead Act was understaffed with personnel, most of whom had little training and minimal supervision. Indifference to the law and corruption among state and local officials also created problems for enforcement.

Despite these difficulties, death rates due to alcoholism and cirrhosis fell dramatically during the first few years of Prohibition. These rates started to climb again slightly in the middle 1920s, but remained below pre-Prohibition rates for several years after Prohibition was repealed.

Political support for Prohibition eroded rapidly following the presidential election of 1928. Policy for the continued implementation of Prohibition became a major issue during the election campaign. Prohibition’s supporters remained rigidly opposed to any modification of the Volstead Act, while the opposition organized quickly and flexibly at both state and national levels to create a state-by-state Constitutional referendum process. The referendum resulted in repeal on December 5, 1933, when Utah became the thirty-sixth state to ratify the 21st Amendment. Ironically, advocates of the Repeal Movement used political organizing strategies very similar to those used by Prohibition’s advocates fifteen years earlier. Prohibition’s rapid and unexpected political defeat closely mirrored its surprising earlier success.
Control, Treatment, and Recovery Era (1933-present)
State and local controls over the legal availability of alcoholic beverages followed Prohibition’s failures. Public controls over alcohol availability and arrests for public drunkenness dominated community efforts to prevent alcohol-related problems in the period from 1933 to about 1960. From about 1960 on, medical treatment services and recovery programs, both of which began in the U.S. in the 1930s, assumed increasing importance as strategies for reducing community alcohol problems.

The Control, Treatment and Recovery Era continues today as a major movement for prevention of AOD problems, joined by the Public Health Movement and the War on Drugs that began in earnest in 1970.

Availability
The 21st Amendment gave states the power to control the manufacture, transportation, and sale of alcoholic beverages. This delegation of power resulted in the rapid establishment of state ABC (alcoholic beverage control) agencies. Thirty-three states adopted “license” systems (California among them) which license private producers, wholesalers, and retailers to do business in alcoholic beverages. The remaining states adopted “control” systems in which the state government itself created a state LCC (liquor control commission) which operated some or all off-sales retail outlets that sold alcoholic beverages.

Alcohol became widely available soon after the Repeal Amendment passed. State controls of alcohol rapidly converted what had been an illegal business system into a legal one. In California, many former bootleggers soon became well-respected liquor-store owners. State ABC regulations served primarily to create orderly markets for state-supervised management of community-level alcohol availability. The California ABC's primary goals, largely achieved and still firmly in place today after the ABC was reconstituted in the mid-1950s, were to establish a profitable (taxpaying), crime-free industry regulated by a corruption-free state agency.

Alcoholic beverage manufacturers increased production quickly following the repeal of Prohibition. Technical advances in production, transportation, and marketing helped the alcoholic beverage industry steadily increase the amount and types of alcoholic beverages available to the public. Per capita alcoholic beverage consumption in California and the rest of the country rose steadily from 1933 into the early 1980s, when it began to level off. The long period of post-war prosperity from the late 1940s to the early 1970s further contributed to increased consumption.

Problems
From 1933 to about 1970, the control era shifted focus on the origin of alcohol problems in U.S. society from the environment (the saloon, the alcohol industry, the problems of society) to the individual (the alcoholic, the inexperienced drinker, the victim of unfortunate events). Societal responses to alcohol problems focused heavily on the treatment of alcoholic individuals, and on the prevention of alcoholism.

The public sector took special notice of chronic alcoholics, especially war veterans eligible for treatment in the Veterans Administration system, and skid-row alcoholics and
indigents seen in the alcoholism wards of state hospitals, in local public hospitals, and in county jails. Direct treatment for alcoholism was not generally available in the private sector.

Although alcoholism was widely acknowledged to be a disease, insurance coverage was not generally available to pay to treat it, and many physicians declined to treat alcoholic patients. Alcoholics and their families often denied their alcoholism. Although Alcoholics Anonymous remained open to all comers, in its early years it was widely viewed as being most suitable for older white working-class men who had been drinking for many years.

The political and economic rationalization of the alcoholic beverage industry, accompanied by extensive advertising and marketing to promote only the virtues and pleasures of consuming the industry's products, removed the alcoholic beverage industry from scrutiny as a contributor to individual alcoholism or other alcohol-related societal problems.

Various problem-rates grew as consumption levels increased steadily for more than forty years, including alcoholism and alcohol-related diseases, drinking-driving crashes, and young people's use of alcoholic beverages. Increases in these problem-rates over time also were due to societal changes as well as to the direct effects of availability and consumption (e.g., more people owned cars and drove them longer distances). However, until 1970 relatively little attention was paid to these problems, and data to describe them were not routinely collected, reported, or analyzed.

Responses
State ABC Controls
Control of alcoholic beverage availability became a preoccupation of prevention planners as Prohibition ended. The states had little advance notice and little assistance implementing the Repeal Amendment.

ABC administrations were especially concerned about problems related to crime and vice in individual alcohol outlets, and about the prevention of economic crime in the manufacture and distribution of alcoholic beverages.

The California ABC followed the general example of other states in its design of a state control system based on oversight of case-level operations for manufacturers, distributors, and retailers. The California ABC lacked resources to monitor the cumulative effects of its operations on the case-by-case basis. The ABC also lacked resources to collect additional data or to perform studies on alcohol-related public health and safety problem-rates at either the state or community level.

Primary Prevention Programs
From the mid-1930s into the 1960s, heavy focus on treatment of individuals detracted attention from the prevention of community-level problems. Primary prevention activities during this period were few, consisting mainly of education and early case-finding in support of the alcoholism treatment and recovery programs described below.

Alcoholism Treatment and Recovery Programs
The alcoholism movement took root in the U.S. during the 1930s with the emergence of
Alcoholics Anonymous and medical research into alcoholism.

**Alcoholics Anonymous**

Alcoholics Anonymous, founded in 1935, became a model for self-help and mutual-help recovery. AA chapters are listed in the telephone book in nearly all California communities. The AA philosophy underlies today's recovery programs for a variety of problems ranging from obesity, to gambling, to mental illness, to sexual behavior. The AA codified the mutual-help recovery process in a highly-readable "Big Book" by Bill W., a founder of the AA, that outlines twelve steps and twelve traditions which, when pursued in the fellowship of AA meetings in the company of other recovering people, help alcoholics remain sober "one day at a time" for the rest of their lives.

**Social-model, Community-based Recovery**

The AA's basic methods recall those of the early temperance era's community-builders who relied on their common purpose as the primary means of support to attack problems of excessive drunkenness in their communities. The founding of the AA led, in the late 1940s and early 1950s, to a widespread network for sober living in the fabric of the community--halfway houses, sober-living residences, sober drop-in facilities to support AA social activities, and Al-ANON Clubs. These "sober places" provided a vital social "base" to help individuals maintain their recovery. Superseded in the 1960s and 1970s by medical-model treatment settings (see below), these far less expensive but effective social-model settings have been making a comeback since the mid-1980s.

**Medical Treatment for Alcoholism**

The concept of alcoholism as a treatable medical disease is approximately 60 years old. The disease concept of alcoholism owes much to work by Dr. E.M. Jellinek and his followers at Yale, who studied alcoholics in AA and in alcoholism treatment clinics. Benjamin Rush first foreshadowed the disease concept in his discussion of "addiction" in the early 1800s. Advances in medical techniques and in the stature of medicine steadily increased resources and benefits for patients receiving treatment for medical ailments related to drinking. Articulation of the disease concept of alcoholism in the 1940s helped create a favorable public perception of alcoholism as a treatable ailment whose sufferers deserved compassion and care, rather than as a moral failing of miscreants who deserved incarceration or neglect.

**The Alcoholism Treatment and Recovery Service Systems**

Medical professionals, counselors, and others provided treatment for alcoholism through programs of medical care, including emergency care, outpatient services, inpatient services, and ancillary/follow-up support services, including referral to Alcoholics Anonymous and social services for help with social, legal, and income-related problems. Several standardized approaches (procedures) were developed, such as 28-day residential treatment (inpatient) programs in the Veterans Administration. This comprehensive system of medical and social services in theory serves currently as the basis for in-community care of alcoholics.

Funding for this system of treatment and recovery services remained woefully inadequate until the development of the National Institute on Alcohol Abuse and Alcoholism (NIAAA) in the 1970s. The NIAAA was developed in part to secure a broad
base of support, including both private insurance and public funding, to establish this treatment and recovery system at the community level.

Incarceration for Public Inebriation

Until the states adopted a national standard in 1972 that made public inebriation a civil matter, California communities treated public inebriation as a criminal offense. Arrested offenders were taken to jail "dru4e-tanks" or to a hospital emergency room if one was available. This "revolving door" system for incarceration had virtually no success in treating or preventing chronic inebriation, though it provided a gateway to treatment and recovery services when supplemented by opportunities to dry out and regain one's health at county jail farms or mental hospital alcoholism wards.

The Public Health Movement (1970-present):
A New Perspective on Alcohol Problems and Alcoholism

The Public Health Movement has added a new perspective regarding concepts, strategies, and federal resources to assist control, treatment, and recovery activities at the state and local level. State and local efforts were vastly supplemented by federal resources beginning in about 1970.

Although public health perspectives on AOD-related problems had been developing since the 1930s, the appearance of two new federal agencies marked the beginning of the public health era for alcohol and other drug problems -- the National Institute on Alcohol Abuse and Alcoholism (NIAAA), formed in 1970, and the National Institute on Drug Abuse (NIDA), formed in 1973.

Beginning in the 1950s, public health planners, the medical community, and social service providers were concerned that not enough was being done to treat and prevent alcoholism and related alcohol problems. Alcoholism had become a medical stepchild, not receiving full attention from public health agencies, hospitals and clinics. Emergency rooms and psychiatric facilities repeatedly admitted, treated, and discharged alcoholic patients in an endless "revolving door" cycle. Since neither treatment nor jail seemed to have much effect, public health specialists and researchers sought out new methods and new approaches leading to the public health perspective that became national policy with the start-up of the NIAAA and NIDA.

Alcohol in Society:
Origins of Problems and Strategies for Prevention

Public health planners were equally concerned about the health of individuals and communities. Communities encompass groups of people which can be defined in various ways, including affinity-based definitions (people who are like each other) and geographically-based definitions (people who all live in the same general area).

Threats to the health of individuals and communities come from several sources: from the surrounding environment, from within individuals, and from interactions between people and their surrounding environments. For example, certain features of the surrounding environment may carry a high risk of harm, such as speeding cars on narrow streets. Certain predispositions within individuals may leave one vulnerable to illness, such as genetic vulnerability to alcoholism. Certain relationships between high-risk environments and vulnerable individuals carry especially high risks for harm, such as a blind person walking
down the narrow street with speeding cars.

Public health planners and researchers noted that prevention interventions could be directed at all three sources of problems—general community environments, individuals predisposed to problems, and settings and circumstances especially prone to problems. The task facing local communities is to identify the risks of problems particular to the community from each of these sources, and to develop appropriate prevention initiatives to reduce the risks.

**The Social Epidemiology of Alcohol Problems:**

**Community-level Problem Assessments**

Public health planners and researchers began working in earnest in the mid-1960s to identify high-risk environments, vulnerable individuals, and high-risk situations and circumstances. The studies, especially those based on random interviews of a cross-section of the general population, found that individuals were not solely responsible for a community’s alcohol problems. General environments of alcohol availability and special drinking circumstances also contributed to the problems.

Work continues today to develop problem-assessment strategies to identify high-risk environments, groups, and circumstances at the community level. Assessment of a community’s alcohol problems is now accepted as a vital starting point for local prevention initiatives. The two approaches most in use are surveys of the local population, and the collection of data from local agencies including the police, health care agencies, and social service providers. Other strategies included focus groups, review of historical records and newspapers, and direct site-observations of high-risk settings and circumstances. Information also can be used that has been developed by other similar communities, and data can be extrapolated from state and federal sources for local application.

Better sources of information for problem-assessment and prevention planning are being developed. Surveys that provide full and accurate information are expensive, and local official data collection systems still leave much to be desired.

**Public Health Prevention Strategies and Community-level Prevention Planning**

Three basic strategies are used to prevent or reduce alcohol problems from a public health perspective:

- **Educational approaches** are directed at groups and at individuals to inform, instruct, and persuade people to participate in community-level prevention initiatives.
- **Normative approaches** are directed at the modification of high-risk community environments of alcohol use and availability.
- **Regulatory approaches** are used to control specific high-risk settings or circumstances, usually by disallowing or curtailing access or use of the affected settings.

Community-level prevention planning with the combined use of these three basic approaches seems far more effective than the single use of any one approach. Community-level prevention planning has grown as a fourth approach that combines the three earlier approaches with each other. The combination of approaches provides many
opportunities to deal with a number of AOD-related problems. Prevention strategies that combine the three approaches are limited only by the imagination of local prevention planners. Recent community-level initiatives, described further below, have found promising results in the combined use of strategies to reduce AOD-related problems at the community level. As local experience in prevention planning has accumulated, increasingly powerful and creative approaches to community-level prevention planning are being developed.

**Availability**

Alcohol availability rose steadily in California from the 1930s to the mid 1980s, then leveled off as measured by the per capita distribution of retail alcohol outlets in the state. Alcoholic beverage consumption rates have followed a similar pattern. Alcoholic beverages today are physically and economically as available in most California communities as are soft drinks, juices, coffee, milk and other regular domestic beverages. Alcohol retail prices are comparable to these other commodities.

Alcoholic beverages are fully integrated into virtually all settings for everyday social life in almost all local communities in California. In recent years, limits have been placed on the availability and use of alcoholic beverages in some of these settings: bars and restaurant operations (especially regarding drinking and driving); the distribution and operation of retail alcohol outlets at the community level; billboards and public advertising of alcoholic beverage availability; public events and public facilities at which alcohol is sold, such as baseball stadiums and city parks.

**Problems**

Alcohol problems are involved in all sectors of everyday community life. Local police departments report that between one-third and one-half of all police arrests involve drinking; hospitals report similar figures for involvement with alcohol problems among general-medical inpatients.

The full range of alcohol-related problems in all sectors of the local community is not fully known. Improvements are needed in official reporting systems and community assessment strategies to make sure this information is widely available at the community level. Meanwhile, formal assessments in a number of communities are turning up similar findings. One assessment found that public officials and community leaders in four California cities reported that the same types of alcohol-related problems were each community's main concerns about alcohol, though not necessarily in the same order: (a) drinking and driving; (b) young people's access to alcohol; (c) assaultive violence and drinking (especially in domestic violence); (d) drinking in public and public inebriation.

**Responses**

During the 1970s and 1980s local communities used demonstration grant funding to find out what "worked" for prevention. At first, local communities explored prevention planning largely on their own, through trial and error, while AOD researchers conducted evaluations of community efforts. From the middle 1980s on, AOD researchers began to take more active roles in the prevention projects, including specification of the prevention interventions and the use of quasi-experimental research designs.
Single-method, Short-term Prevention Strategies
Communities began exploring the use of three distinct strategies or approaches for community-level prevention of AOD-related problems: educational approaches, normative approaches, and regulatory approaches. Initially, these approaches were used in isolation from each other on a short-term basis, in keeping with restrictions of demonstration-grant funding.

Educational Approaches
Educational approaches seek to reduce or prevent AOD-related problems by increasing individuals' knowledge of the problematic effects of alcohol and drug use, and by increasing their skills and abilities to use this knowledge to prevent or avoid problems.

Early approaches to community-level prevention in the 1970s and early 1980s emphasized freestanding, single-setting educational approaches. These approaches emphasized educational activities only, that is, "freestanding" activities unrelated to other activities or services in the community. Implementation of these early approaches usually was restricted to brief sessions in a single type of setting, usually classrooms.

These early educational programs often successfully changed knowledge and attitudes over the short term (several months to one year), but had few discernible lasting effects on alcohol and drug-using problem-behavior. Later versions of the same types of programs have not been more productive. Multi-grade programs (Here's Looking at You) and programs that used authority figures such as police officers (DARE) continue to show little influence on alcohol and drug-using problem-behavior.

General conclusions at present are that educational approaches alone do not effectively reduce alcohol use and problematic drinking. Educational approaches are being used increasingly in combination with the normative and regulatory approaches described below. Local primary/secondary school systems, colleges, and adult education programs for alcohol and other drugs are increasingly involved with other community agencies and organizations, especially the justice system, and social and health services.

Normative Approaches
Normative approaches seek to reduce or prevent AOD-related problems by changing community-level practices and beliefs regarding the use of alcohol and other drugs. Regarding alcohol, efforts are made to change drinking practices to reduce or eliminate associated problems, and to revalue the meaning of drinking practices to win people's acceptance for these changes. Changed community-level drinking norms include abstinence for all under-aged drinkers. Regarding illicit drug use, efforts are made to gain community acceptance for practices and beliefs that eliminate all availability of illicit drugs, and that reject all illicit drugs use.

Local communities began to pursue normative approaches in the mid-1970s. Special efforts were made to secure voluntary adoption of new preventive practices, and to create prevention-oriented public information campaigns at local and state levels. The federal government directly supported national public information prevention campaigns until 1980, and since then has encouraged private nonprofit foundations to do so. Beginning in the mid-1980s, the federal Center for Substance Abuse Prevention (CSAP) especially encouraged adoption of a norm-change approach (the "paradigm shift")
applied through its "Community Partnership" programs, and through the six categories under which states are funded to support prevention activities.

**Voluntary Agreements**
Local public agencies, businesses, and other community organizations can agree voluntarily to adopt preventive policies and practices regarding AOD availability and use. Numerous attempts have been made since the 1970s to use voluntary agreements to modify policies and practices regarding alcohol use in community settings. Examples include workplace practices regarding drinking, retailer practices regarding alcohol sales and serving practices (especially to minors and to drinking-drivers), public agency policies regarding the use of alcohol at public events and in public places, and "social-host" standards for private entertaining.

Communities generally have experienced considerable difficulty in gaining successful adoption of voluntary agreements communitywide. Issues of widespread acceptance and compliance pose challenges to the use of voluntary agreements as community policy. Additionally, efforts to evaluate the use of voluntary agreements has not received much attention from researchers.

**Advertising and Labeling Campaigns**
Community-level prevention advertising and labeling campaigns have continued to develop steadily since the early 1970s. Although there are several reasons to believe that advertising and labeling have preventive influences, the particular effects of specific prevention-oriented advertising campaigns and warning messages cannot be evaluated easily. Partly this is because of the overwhelming volume of other messages influencing behavior, including alcoholic beverage industry advertising and portrayals of alcohol and drug use in the news media and in movies, TV shows, and other entertainments. Partly this is because many other activities involved in putting together a prevention campaign (creating a coalition to support the campaign, meeting to plan campaign activities, gaining support from sponsors, etc.) also have preventive value that must be taken into account.

**Regulatory Approaches**
Regulatory initiatives set physical, economic, and age restrictions to limit access to alcoholic beverages. Generally, regulatory approaches show some successes in reducing alcohol-related problems provided the regulations are accepted by the groups who are subject to the regulation (see Normative approaches) and are appropriately implemented by community organizations and authorities having jurisdiction.

**Controls on Alcohol Availability at Special Events**
Controls at mass events, fairgrounds, and at stadiums have successfully reduced problems related to patron behavior during the event and to drinking and driving following the event.

**Controls on Retail Alcohol Outlets**
Lower densities (outlets per population) of retail alcohol outlets are associated with lower rates for traffic crashes, assaults, and homicides. Though deliberate attempts to reduce problem-rates by reducing outlet-densities have yet to demonstrated, considerable anecdotal evidence from police and ABC officials indicates that problems
decrease when high geographic concentrations of outlets are reduced. Local planning and zoning officials have reported fewer problems with retail alcohol outlets that are subject to stricter scrutiny (case-by-case reviews rather than general requirements).

**Economic Controls**
Controls such as increased taxes that effectively raise the unit price of alcohol have successfully reduced consumption and consumption-related problems such as drinking and driving.

**Age Restrictions**
Increases in the minimum purchase age clearly reduce drinking-driving crashes; decreases in minimum purchase age increase drinking-driving crashes. Vigorous enforcement of minimum purchase ages through "sting" operations is effective in the short-term in reducing sales of alcoholic beverages to underage purchasers.

**Combined and Sustained Prevention Measures**
Local communities are beginning to use a combination of educational, normative, and regulatory strategies to act on specific AOD-related problems that have been identified through the problem-assessment process. No one prevention strategy alone appears sufficient to maintain community-level prevention policies and programs; but taken together, and applied overtime in settings throughout the community, prevention initiatives based on these strategies appear to have a cumulative effect in reducing AOD-related problems.

**Drinking and Driving as an Example of Combined Approaches**
Drinking-driving initiatives provide a national example of the combined, sustained approach to reduce alcohol-related traffic injuries and crashes. Drinking-driving campaigns sponsored by the federal government's Alcohol Safety Action Project (ASAP) in the mid-1970s set the stage for later efforts. ASAP projects created public awareness of the drinking issue where virtually none had existed before, for example, by using video cameras to shock drivers with the extent of their impairment when arrested for DUI. The next twenty years saw extensive public information campaigns, the passage of several laws (the.08 BAL standard for legal intoxication, administrative license revocation, zero-tolerance laws for underage drinkers), increasingly stiff enforcement, roadside breathalyzer checks, holiday anti drinking-driving campaigns, designated driver programs, and the grassroots Mothers Against Drinking Drivers (MADD).

Over the years, DUI rates and alcohol-related crashes have continued to drop steadily. No one prevention strategy is responsible, but cumulatively all are having some effect. Additionally, other prevention measures may also have had an effect (seat belts and airbags, safer roads and automobile designs, the 55 mph highway speed limit). Alcohol-specific prevention measures and other health and safety measures may be synergistic for each other.

**Combined, Sustained Prevention Initiatives at the Community Level**
Local community prevention programs at the municipal and county level have not been operating long enough to create the integrated, sustained approach shown by the example of drinking-driving prevention initiatives. However, many communities have begun to develop combined, sustained approaches as they convert from demonstration-grant funding into self-sufficient local programs.
Taken together, educational, normative, and regulatory prevention strategies offer enormous potential for developing a combined, sustained program at the community level. California communities have only just begun to explore the full scope of the resources already at their disposal to develop this potential.

**Need for Community-based Planning Bodies**
The development of a community-level combined, sustained prevention initiative requires central community planning that will continue regularly and indefinitely. The community’s prevention planning group must be able to bring together the sectors of the community concerned about alcohol problems, and must provide a vehicle for their collaboration to develop complex prevention initiatives. The planning should be as free as possible from distraction with other issues, and should be free of bias against using a variety of prevention strategies.

**Full Circle: From Early Temperance to Current Local Prevention Initiatives**
National emphasis on prevention of alcohol problems has turned once again to action by local communities, particularly cities and counties, to take the initiative to prevent AOD-related problems. This time the orientation is much more self-conscious and deliberate. Local communities today have more powers to manage alcohol and drug availability than did their counterparts 160 years ago, and state and federal resources are more plentiful, including information, technical assistance, and limited funding.

Community sentiment regarding prevention also is more sophisticated today than it was then; today few people favor prohibition, but many more are persuaded that preventive management of alcohol availability and its use is highly desirable. Additionally, more effective prevention strategies are available today through modern public health strategies and public policies for the control of alcohol availability. Many of the strategies of 100 years ago, such as limiting availability to minors, are as useful today as ever.

The pressure for prevention runs in both directions today. In the early 1830s, the temperance movement was essentially a grassroots and community-based movement that ended up gaining national support. Today, many national public officials and national leaders in the fields of public health and safety lend their support to community-level prevention initiatives, even if the purity of their motives can be questioned. Putting responsibility on local agencies and organizations is a good way to remove a difficult burden from state and federal shoulders; state and federal interest is admirable only if state and federal agencies fully support the capacity of local governments and community groups to take responsibility for prevention initiatives.

**State of California Programs for the Prevention of AOD Problems**
Three state agencies have played significant roles in the development of agency-initiated community-level prevention programs since 1970.

**Department of Alcohol and Drug Programs (ADP)**
Since the middle 1970s, this state agency has provided leadership in the field of community-level prevention planning through four programs.
Direct Assistance for Community-level Prevention Planning
A series of conferences, workbooks, and pilot projects in the early 1980s provided guidance to local communities on environmental strategies for the prevention of AOD-related problems. Two community planning workbooks (1988 and 1990) and demonstration projects in four communities 1990-1995 further refined effective prevention planning strategies. A vigorous technical assistance program in all facets of prevention planning is available on request.

Programs for Young People
The Department’s Friday Night Live and Club Live programs, providing prevention programs for high-school age and grade-school age young people respectively, were moved from in-house to contracted programs in 1994.

Support for County-level Prevention Initiatives
In coming years ADP will put greater emphasis on county-level initiatives to activate community planning, relying on a combination of federal block-grant support (see below) and the availability of planning information and short-term technical assistance directly from the ADP. Special assistance will be provided in community organizing and other selected topic areas to be determined.

Information Services
ADP hosts quarterly meetings to review the epidemiological information about the state's drug problems, and in the coming years will be providing additional program evaluation information and statistical information about the extent of ACID problems for county and local planners.

Department of Alcoholic Beverage Control (ABC)
ABC regulates all aspects of the production, transportation, and sale of alcoholic beverages. A network of district offices throughout the state reviews applications for retail licenses. The review process provides opportunities for local police departments, other public agencies, and community groups the opportunity to protest the application for a license, or to file an accusation against the operation of an existing outlet.

The ABC is thinly staffed (250 officers to cover 70,000 retail alcohol outlets), and so local communities must do their own homework to make effective use of ABC resources. Work with the ABC is greatly enhanced when the local city or county has a strong planning and zoning ordinance, since the ABC defers to local conditional use-permit reviews of retail alcohol outlets.

The State Attorney General’s Office
Every two or three years, the Attorney General's Office publishes a survey of alcohol and drug-use among 7th, 9th, and 11th grade students in California schools. This standardized survey provides a uniform review of AOD-use and problems among young people throughout the state.

Federal Programs for Prevention of AOD Problems
The selected programs described below provide support to California communities directly or indirectly through state agencies. Further information about each of these programs can be obtained from the county alcohol and drug program agency, from the agency named in the
description, and particularly the National Center for Alcohol and Drug Information (NCADI).

**Federal Grants for Demonstration Programs and Innovations** These are short-term, one-time grants to explore application of new concepts and strategies for community-based prevention activities. Initiative is left almost entirely to the local community; little external guidance or control is provided other than the original grant application specifications.

**CSAP (Center for Substance Abuse Prevention)** Since 1985, CSAP (formerly the Office of Substance Abuse Prevention, or OSAP) has provided twenty-six Community Partnership comprehensive planning demonstration grants to California communities, as well as a number of grants for specialized conferences and services.

**NIAAA (National Institute for Alcoholism and Alcohol Abuse)** NIAAA is participating with CSAP in funding two comprehensive community prevention planning projects in Oceanside and Salinas. For the past twenty years NIAAA's Prevention Division has funded both basic and applied prevention grants to highly-qualified researchers to rigorously test various methods for preventing alcohol-related problems. NIAAA also supports epidemiological studies to describe the prevalence and incidence of public health problems.

**NIDA (National Institute for Drug Abuse)** NIDA's prevention and epidemiology research program conducts studies similar to the NIAAA to test a wide variety of methods for dealing with problems related to illicit drugs, particularly for school-age children and young people.

**NHTSA/OTS (National Highway Traffic Safety Administration, Office of Traffic Safety)** OTS grants are given out annually to California public agencies and nonprofits through the Department of California Office of Traffic Safety. Grants are for community-based projects to explore innovative strategies for the prevention of alcohol-related highway crashes.

**Federal Block Grants** Federal money is given directly to two California state agencies for distribution to local community prevention initiatives. The California Department of Alcohol and Drug Programs receives block-grant funds for prevention programs. The California Department of Education receives funding for the AOD prevention programs to be provided under the Safe Schools and Communities Act.
SECTION 11: ILLICIT DRUGS

The Colonial Era (1730-1830)
The use of mind-altering drugs (other than alcohol) was not a problem during this era. New discoveries of mind-altering drugs had yet to made; little record exists of problems with the naturally-occurring substances already known to native Americans, such as peyote.

The Industrial Era (1830-1918)
In the mid-1800s, the discovery of narcotics led to problematic medical and social experimentation that resulted in the first public controls on the sale and use of drugs.

Availability
Nineteenth Century advances in medicine and chemistry saw the discovery and invention of a wide variety of psychoactive drugs, including narcotics or depressants (opium, morphine, heroin, codeine, chloroform); stimulants (cocaine, amphetamines); and psychedelic or hallucinogenic drugs (mescaline). A great deal of experimentation occurred with these new drugs. Morphine’s use to treat an estimated 400,000 soldiers during the Civil War caused morphine addiction to be known for a time as the “soldier’s disease.” Cocaine was widely used in patent medicines and tonics, with some unfortunate results. Examples were Vin Mariani, a “health food” that contained a mixture of cocaine and wine and Coca-cola, a “refreshment” that originally contained cocaine and caffeine.

Cultural practices of different groups in an increasingly diverse society also contributed to drug use. For example, religious uses of peyote and recreational uses of marijuana spread from the Southwest and Mexico to California cities. Opium-smoking flourished in cities with recent immigrants from China.

Problems
The unregulated environments of invention, experiment, and entrepreneurship that prevailed at the time led to high levels of use and personal experimentation with drugs. Two results were high levels of addiction and scandalously unfortunate experiences resulting in disability or death, such as harm done to infants and children whose mothers unwittingly gave them excessive doses of unlabeled “tonic.”

Cultural differences in drug-use patterns were interpreted to support prejudices against foreigners and people of color, and to suppress the spread of these drug-use patterns into the general population.

Responses
Local and State Controls
Communities responded by proscribing the manufacture and importation of these drugs, and by otherwise restricting their use and distribution. By the early 1900s, many local communities had begun to pass laws against the sale or use of narcotics. For example, by 1914, 27 cities and states had followed San Francisco’s 1875 lead in banning opium dens.

National Controls
Pharmaceutical manufacturers and physicians joined concerned community groups in recommending stricter controls on importation of narcotic drugs from the federal
government. Congress obliged by passing several pieces of restrictive national legislation, such as the Opium Exclusion Act of 1904 that disallowed further importation of "smoking opium" into the U.S.

The 1914 Harrison Act was the first anti-drug law that effectively proscribed dispensing and use of drugs such as opium and morphine. The act required a special tax stamp for the production, transportation, or sale of narcotics. This meant that all such traffic must be registered, and thus opened the door to increasingly strict requirements that limited legal use of these drugs to physician-prescribed treatment for disease or discomfort, excluding prescriptions for maintenance of addicts' habits.

The Prohibition Era (1919-1933)

Availability and Problems
The Harrison Act made legal supplies of narcotics generally unavailable to addicts; availability in itself became a problem for addicts. Clinical treatment and various therapies and cures had extremely low success rates, and addicts increasingly turned to the black market for drugs. Sensationalized press coverage of illegal drug use brought the subject into public consciousness, widely associating illicit drug use with criminal behavior and the need for state control. Relatively mild drugs such as marijuana, which had long been medically prescribed in the U.S. without problems, were declared dangerous when used illegally for recreational purposes.

Responses
Prevention policies took several forms, none of them particularly effective at reducing current levels of use:

Marginalization of Illicit Drug Users
Sentiment turned against users of illicit drugs, opening the way for the application of increasingly punitive approaches to individual drug users.

International Suppression of Production and Export of Narcotic Drugs
The 1931 Geneva Conference on the Limitation of the Manufacture of Narcotic Drugs regulated all aspects of the international drug trade, from raw material to pharmacy, including special attention to the detection of treaty violators.

Domestic Suppression of the Sale and Use of Narcotics
The Federal Bureau of Narcotics was established in 1930, and the Uniform Narcotic Act required standardized record-keeping of drug prescriptions and sales. Talk of a "war on drugs" began to appear in newspapers and the popular press.

Control, Treatment, and Recovery Era (1933-present)
Policy programs to prevent use of illicit drugs during this period cast users of depressants (narcotics) and hallucinogenic drugs as deviant, dangerous individuals living at the margins of society. These individuals were subject to increasingly punitive sanctions.

Availability
Marijuana, cocaine, heroin, and amphetamines continued to be widely available despite efforts to control their production and distribution. The Vietnam War exposed many soldiers to illicit drugs, and helped stimulate illicit trade worldwide.
Legitimate drug manufacturers created certain new products that were put on the open market, but later were withdrawn for direct public access or were no longer prescribed by physicians. Examples are Benzedrine-filled inhalers and, amphetamine preparations which were widely prescribed for treatment of depression and obesity, and for hyperactive children. Amphetamines also were introduced into medically unsupervised markets and then withdrawn, for example, in over-the-counter weight-loss preparations.

Drugs that were created for which increasingly tighter controls were imposed included LSD (d-lysergic acid diethylamide), demerol, methadone, and PCP (phencyclidine). Tranquilizers (benzodiazepines) were also invented in the early 1950s, quickly taking their place among the most heavily-prescribed medicines.

Problems
Medical use of many new drugs proved problematic because of side-effects and because of difficulties in supervision of their use. The use of a number of these drugs was withdrawn or restricted. For example, Benzedrine was removed from inhalers, use of LSD to treat mental patients ceased, amphetamines were more tightly controlled, and medical use of PCP was stopped for humans and animals. Warnings were issued both to physicians and to the public against the excessive and improper use of barbiturates and tranquilizers.

Despite notification of medical dangers and greater controls, unregulated self-medication, recreational use, and experimentation with illicit drugs continued to expand. Soldiers in the Korean War mixed heroin and amphetamines to create speedballs. The “beat generation” counterculture used marijuana and hallucinogens. Glue sniffing spread among teenagers. In the 1960s, illicit drug use expanded from a deviant activity among marginal social groups to widespread use by young people, including soldiers in Vietnam. Expansion of use occurred particularly for marijuana, cocaine, and hallucinogens.

Responses
Increased international Controls on the Production and Distribution of Drugs
Several international conferences held in Geneva, Switzerland, resulted in agreements to control all aspects of the growing, production, distribution, and sale of opiates. Controls on coca production were added to the 1951 United Nations Single Convention on Narcotic Drugs.

Increased Sanctions for Narcotics Offenses
Several laws were passed that imposed increasingly heavy penalties for narcotics offenses, including the death penalty for certain types of trafficking.

Increased Treatment for Addicts
Two federal treatment facilities in Kentucky and Texas were established in the late 1930s to create treatment programs especially for addicts. Therapeutic community programs, loosely modeled on the AA, began with Synanon in 1958 to operate specifically for addicts. Methadone maintenance programs were developed for use on an outpatient basis in 1964.
Treatment for Addiction and the War on Drugs (1970-present)
The appearance of a special White House office on drugs, the Special Action Office on Drug Abuse Prevention, formed in 1972, marked the beginning of expanded federal efforts to eliminate the availability and use of illicit drugs.

The Office of National Drug Control Policy and the Drug Enforcement Administration
Since the early 1970s, the federal government has maintained a special action office for illicit drug problems in the White House, Coordination of enforcement and prevention programs to attack problems related to illicit drugs is currently handled by the Office of National Drug Control Policy (ONDCP), which reports directly to the President. The primary federal agency responsible for enforcement activities directed at illicit drug use is the Drug Enforcement Administration (DEA), which works with other federal agencies such as the Federal Bureau of Investigation (FBI) and Bureau of Alcohol, Tobacco, and Firearms (ATF), and with local police departments. The War on Drugs appears unlikely to continue in its current form; many observers believe that its results to date have not justified its expense.

Supply-side Approaches
Since the 1970s-the federal government has pursued a two-pronged approach to suppress the production and use of illicit drugs. The "supply side" approach seeks to limit production, distribution, and sale of illicit drugs. A combination of international measures, border controls, and domestic enforcement activities has been employed. The federal government spent more than $8 billion on these efforts in 1993, up from $1.6 billion in 1981.

Much of this money has been spent on incarceration of drug dealers, and prison populations have risen dramatically across the country. California's prison population more than doubled from 1980 to 1993, now standing at more than 140,000 inmates on an typical day.

The value of these enforcement efforts has been called into question by a study by the Rand Corporation which successfully predicted that even a doubling of the enforcement budget would not significantly affect the street-price of illicit drugs. The street price of drugs, which is a good predictor of levels of drug use, is essentially the same in the mid-1990s as it was in the mid-1980s.

Demand Reduction
The "demand reduction" approach seeks to limit personal use of illicit drugs through education and treatment activities directed toward drug abusers. The federal government spent more than $4 billion on these efforts in 1993, up from less than $1 billion in 1981. Vast increases in funding have been credited with reducing casual use of illicit drugs, although rates of marijuana and cigarette smoking among young people have begun to increase since 1993. Rates of drug-use among addicts and heavy drug users do not appear to have changed significantly. For example, rates of HIV infection among needle-users remain persistently high despite extensive outreach and prevention efforts. Treatment programs do appear to reduce illicit drug use, saving an estimated seven dollars for every one spent on treatment according to one study.
**Availability**
Illicit drug availability remains as high today in California as it has ever been. Drugs are more potent, and continue to appear in new forms. Marijuana is ten to twenty times stronger now than it was twenty years ago. Chemists continue to create new psychoactive drugs, “designer drugs,” which federal authorities promptly schedule as proscribed substances under the Controlled Substances Act of 1970.

Attempts to proscribe the non-medical use of proscribed depressants, stimulants, and hallucinogenics have not significantly reduced the community-level availability of these substances. Instead, local communities today are subject to successive waves of illicit drug availability as suppression of one or another source or type of drug is countered by re-supply, new sources and alternative drugs.

**Problems**
Illicit drug use at the community level is associated with crime problems, social problems, and health problems. Crime includes thefts and robberies to purchase drugs, violence and intimidation, the costs of law enforcement, and diversion of money out of the legitimate economy. Drug-related social problems include deteriorated quality of neighborhood life, alienation and diversion of young people into the drug trade, personal dependency and family dysfunction. Drug-related health problems from illicit drugs include trauma, addiction, morbidity and mortality from continued drug use and overdoses.

A community’s problems with illicit drugs generally are only a small fraction of the community’s alcohol-related problems. Typically illicit drugs create about one-tenth the problems due to alcohol in terms of the use of public resources such as police, health-care services, and numbers of individuals affected. Additionally, use of alcohol very often accompanies the use of illicit drugs either as a companion beverage or to moderate the drugs’ effects. Accordingly, prevention initiatives aimed at alcohol-related problems will automatically have some effect on problems with illicit drugs.

The fact that alcohol problems may be much greater is small comfort to the segments of the community most affected by illicit drug sales and use, particularly when the quality of daily life is nil due to fear, intimidation, and the ever-present threat of violence. A major social problem with illicit drug use is that the most vulnerable parts of the community with the fewest resources are the areas most heavily affected by illicit drug sales and use. Prevention programs are more difficult to develop and sustain in these distressed areas.

**Responses**
The concept of combined, sustained community initiatives for prevention of alcohol-related problems is fully applicable to problems of illicit drugs. The basic division of prevention strategies into educational, normative, and regulatory approaches is effective, although it is controversial with respect to the regulatory approaches.

While the War on Drugs continues its current policies for intercepting and confiscating illicit substances, incarcerating dealers, and seizing their property, alternate prevention strategies are being explored for community-level prevention initiatives.

**Augmented Educational Approaches**
Freestanding educational approaches have not been successful when applied to illicit drug
use; in fact, early school-based educational programs of the late 1970s may actually have encouraged experimentation with illicit drug use. More recent educational approaches combined with specialized training and social supports have been effective in delaying the onset of illegal drug use, in moderating the extent of use, and in reducing problematic consequences of use.

**Risk-reduction and Resiliency Training**
These programs alert at-risk families and individuals (children and young adults) to understand the high-risk in which they live and to learn how to avoid or reduce trouble.

**Skill building and Mentoring**
These programs provide emotional skills, cognitive awareness, exposure to positive values, personal support, and access to educational and vocational opportunities and other social services.

**Family Skills Programs**
Many problems with illicit drugs begin in early childhood. These programs teach parenting skills and provide support to young and isolated parents, such as teenage mothers abandoned by the father and family.

**Treatment**
Many users who are addicted have a combination of social, legal, and personal problems. Treatment often includes a combination of activities, including education and socialization or re-socialization into the drug-free community.

**Neighborhood Safety Strategies**
Local communities are increasingly using environmental strategies to make their immediate neighborhoods safe. A combination of social, physical, and economic strategies are being employed.

**Neighborhood Watch and Crime Watch**
Organizations of neighborhood residents create local groups that look after each other's property and report suspicious activity to the police. Some neighborhood organizations may develop positive neighboring activities also, such as providing after-school places for children who do not have a parent at home.

**Defensive Design**
Drug-dealing, loitering, and violent activity are discouraged by high-intensity lighting, fenced-off property that denies hiding-places, street-bumps and traffic diversities to discourage cruising and drive-bys, etc.

**Community-oriented Policing (Preventive Policing)**
Local police officers get to know residents personally, are available to assist with problem-solving, and can help plan crime-prevention strategies. This kind of policing has been effective for preventing or stopping drug-dealing at the neighborhood level, and in apartment complexes.

**Nuisance Abatement**
Nuisance abatement procedures are used against property-owners who contributed
directly to drug-related problems in the neighborhood. Courts or local zoning boards' require the owners to take steps to correct conditions that contribute to the problems, or face stiff fines or the loss of their property. Action can be taken through the local city attorney’s office or through local planning and zoning if the city has a "deemed-approved" ordinance that applies to existing land-uses. Alternatively, action can be taken through small claims court.

**Positive Social and Economic Development**
Some argue that problems related to illicit drugs are best ameliorated by decent housing, a sufficient job base, and a viable commercial district that serves residents' needs. Supporters of this position argue that more can be done if the community organizes positively around a developmental purpose, rather than negatively around a defensive one. For example, neighbors may participate more in the development of a specific plan to bring new commercial outlets into an area, than continue to go to zoning hearings to keep out more liquor.

**Decriminalization and Legalization**
An increasing number of policy-makers, researchers, and community advocates have concluded that the federal 'War on Drugs should be replaced by decriminalization or legalization of certain currently-illicit drugs. For example, California and nine other states have decriminalized marijuana by making possession of small amounts a civil offense. Thirty-two other states allow prescription of marijuana for certain medical conditions. California is debating now through the voting system, the legislature, and through the courts to decide if “medical marijuana” will be legal.

Since the federal government’s criminal penalties preempt them, state and local decriminalization laws have no effect at present. However, the arguments persist that decriminalization or legalization will reduce problems rather than make them worse. For example, advocates argue that the prohibition on needle-exchange programs is exacerbating problems such as the spread of AIDS, and would do little to increase addiction were the prohibition removed. Others argue that legalization/decriminalization will increase addiction, and will lead to trading one set of problems for another, claiming that health problems will increase dramatically although crime problems may decrease.

The current controversy is an example of concerns that occur when there is widespread belief that public health programs and law enforcement are not effective or work contrary to their intended effect. The current debate over decriminalization and legalization of narcotics, stimulants, and hallucinogenic drugs is part of a long-running controversy that has waxed and waned in public debate and in court for the past century.