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Ending the "Drug War:" The Public Health Approach to the Drug Problem

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"End the Drug War." That has been a rallying cry for drug policy reformers almost since the "Drug War," aimed at the marijuana, heroin, and cocaine, was first declared by U.S. President Richard M. Nixon in 1971 [1]. In fact, in 1972 there was actually a U.S. National Commission on Marijuana and Drug Abuse report [2], their first, which recommended that marijuana be legalized. But the Nixon Administration would hear none of it. As a former top Nixon aide, John Erlichman, later told us, they wanted to "wage the war" for political, not health-improvement, purposes. This is what Erlichman said [3]:

"Look, we understood we couldn't make it illegal to be young or poor or black in the United States, but we could criminalize their common pleasure. We understood that drugs were not the health problem we were making them out to be, but it was such a perfect issue...that we couldn't resist it. . . . [Nixon] emphasized that you have to face the fact that the whole problem is really the blacks. . . . The key is to devise a system that recognizes this while not appearing to."

And so, once underway, the "Drug War" has proceeded unchecked for 45 years.

The underlying hypothesis of the "drug war" is that:

A) The habituating/addicting drugs of personal use at which it is ostensibly aimed, primarily marijuana, cocaine and heroin, the so-called "illicits," are somehow different in their outcomes than the "licit" drugs of personal use like tobacco products and alcoholic beverages. (Actually they are different. As further noted below, the licits are more harmful to society by many orders of magnitude than are the illicits. But the Drug Warriors, and, as it happens, the bulk of the Drug Policy Reform Movement [DPRM], ignore this fact.)

And B) the "drug war" strategy and tactics holds that criminalizing both the commerce in and the personal possession and use of the "illicits" would somehow reduce the level of their use in society (the ostensible aim of the program). But in fact, all of what I have termed the "Recreational Mood Altering Drugs," the RMADs, whether licit or illicit, are potentially harmful to human health. In fact the two major licits, tobacco products and alcoholic beverages, are far more harmful, in population terms, than any of the illicits. It has always appeared that the division of the RMADs into the "licit" and "illicit" categories was quite artificial. In fact, given the pharmacological/pathophysiological properties of the various RMADs, it has been most arbitrary. The description by Mr. Erlichman of the real reasons for starting the "Drug War" makes that quite plain.

Indeed, the term "Drug War" is here placed in in quotation marks precisely because it is not a war on the use of the RMADs in general. Rather it is rather a very limited war, and not on the particular drugs (as if there could be a "war" on an inanimate object). Rather it is a real war on certain users of certain RMADs [4] (the original "illicits" having been joined in more recent years by the "white heroin," methamphetamine, and the legal opioids like Vicodin and OxyContin sold illegally). The outlandishness of the "Drug War" is also made plain by the fact that the two major RMADs, the ones that wreak much more havoc on the population than the illicits do, primarily alcoholic beverages (about 85,000 deaths per year) and tobacco products (about 488,000 deaths per year including 49,000 in non-smokers, from second-hand smoke) [5], are, with certain non-criminal restrictions, quite legal. Despite these facts, the "Drug Warriors" have managed to maintain the artificial "illicit/licit" dichotomy since the War's inception.

In the United States, the DPRM first became active in the late 1980s. From the beginning, for the most part the formal DPRM [6, 7]: a) has bought into the artificial dichotomy created by the "Drug War" (for reasons that have never been explained to this author, despite numerous requests to have that done) and has gone along with it down to the present time: b) has become more-and-more focused on the decriminalization/legalization of one of the illicits (of course that was marijuana) rather than dealing with the negative health/societal effects of all RMAD-use (which happen to be best dealt with by legal methods), and c) with the exception of Dr. Joyce Lowinson who in the 1990s published a chapter on "The Public Health Approach to the Drug Problem" in the standard textbook Substance Abuse [8] for which she was the Senior Editor, members of the DPRM have never been interested in even discussing the concepts.

The criticisms of the "Drug War" developed by the DPRM are of course entirely sound. It: a) has been totally ineffective in achieving its publicly stated objectives [9], b) has a racist basis that has become ever more apparent over the years [4], c) is enormously costly [9], d) has led directly to the problem of massive incarceration of minority young men [4], e) like U.S. Prohibition, has created a large, very profitable, criminal enterprise which would otherwise not exist, and so on and so

forth. However, the limited DPRM approach to dealing with the drug problem and the "Drug War" remains in place to this very day.

In contrast, the Public Health Approach tells us that if it were to be possible to effectively deal with the negative health outcomes of the use of the illicits, and there are such, one first has to deal with the much more widespread negative health effects of the use of the licits. Further, one has to recognize that it is the use of alcoholic beverages and tobacco products by children that directly leads, through the "Gateway Drug Effect" [10], not only to the use of those two RMADs by adults, but also to the use by teen-agers and adults of the illicits.

And so, the Public Health Approach to the Drug Problem (PHADP) (beginning first for the United States) was developed [11, 12]. It is based on five important principles:

1) The RMAD problem is a unity not a duality;

2) The United States has a broad-based Drug Culture ([13], chap. 2), which not only heavily promotes the use of the "licit" RMADs. It also heavily promotes the use of both pharmaceutical and over-the-counter medications as problem-solvers --- "have a problem? Take this pill" --- when such use is not always indicated and can easily become excessive. (As well, many state governments and private enterprises openly promote a non-drug but highly addictive behavior, gambling.) The Drug Culture will have to be dealt with in one way or another if the drug problem is to be brought under control.

3) RMAD-use, part of human culture apparently since the time that there has been human culture, will never be eliminated, nor should any attempt be made to do that. Rather the focus should be on reducing the negative health effects of their use to the extent possible, using tried-and-true public health methods which, as it happens, have convincingly been shown to work, with cigarette smoking (see below);

4) That at its base dealing with both the "Drug War" and the negative effects of RMAD-use are political/economic problems;

5) That there is a series of major Stakeholders in the maintenance of the "Drug War" ([13], chap. 4), which range, among others, from certain political interests, through the currently licit RMAD industries, through certain elements of the prison-industrial complex, to the drug cartels themselves. They would all have to be dealt with were the PHADP to be introduced and successfully implemented; and thus

6) Along with its many other negatives the "Drug War" actually interferes with solving the drug problem.

But can the PHADP really be successful in dealing with the "drug problem," both for the illicits and the licits? Well, we have right in front of us in the United States an outstanding example of how the PHADP can be very successful, over time. That is of course, the United States' Public Health Service's National Anti-Smoking Campaign which has been in existence since the publication of the first Surgeon General's Report on Smoking and Health in 1964 [14]. This, the most successful non-infectious disease control program ever implemented in the United States, has reduced the rate of adult smoking from 45% in 1964 to about 18% presently [15]. And guess what? It did so without locking up even one cigarette smoker.

The comprehensive PHADP has approximately 20 separate elements [16], ranging from the development of a rational classification system for the RMADs, through the development of a regulated sale model, to the development of a rational RMAD-use control, educational, and advertising campaign. It is explained in detail in the book from which this brief introduction to the subject is drawn.

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