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ALCOHOL AND DRUGS IN A PUBLIC HEALTH CONTEXT: ALCOHOL AND OTHER DRUGS

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Psychoactive drugs are substances that alter the mental state of humans when ingested. There are a wide variety of such substances, naturally occurring and synthesized, including tobacco, alcoholic beverages, coffee, tea, chocolate, and some spices, as well as substances legally available only through medical channels such as benzodiazepides, cannabinoids, opiates, and cocaine. Such substances often have other use-values, along with their psychoactive properties. Users may like the taste, or the image of themselves that the use conveys. Use may be a medium of sociability (Partanen, 1991), or part of a religious ritual. Some substances have other useful properties; alcohol, for example, is a source of calories, and is the solvent in many tinctures.

Psychoactive drugs differ in their metabolic pathways and mechanisms of action in the human body, in the strength of their effects, and in the states of mind and feelings they induce. But the effects of drug use are also powerfully dependent on the pattern of use, and on set and setting -- this is, the expectations of the user and of others present, and the context of use (Zinberg, 1984). While the psychoactive effect of tobacco may not even register in the consciousness of a habituated cigarette smoker, in other circumstances the effect of tobacco use may be so strong that the user is rendered unconscious, as early Spanish observers reported concerning native South Americans (Robicsek, 1978).

Psychoactive substances are frequently valued by potential consumers well above the cost of production. On the one hand, this means that taxes on alcohol, tobacco, and other drugs have long been an important fiscal resource for the state. On the other hand, it means that there are substantial incentives for an illicit market to emerge where sale of drugs is forbidden or stringently restricted.

A consideration of drugs in a public health context may appropriately start from a consideration of general cultural patternings and understandings of drug use. This is followed by a discussion of the major approaches to limiting harms from drug use. We conclude with a characterization of the major directions in the development of drug policies in the U.S. and other industrialized countries.

GENERAL CULTURAL FRAMINGS OF DRUG USE

Three social patternings of psychoactive drug use can be distinguished as prototypical: medicinal use, customary regular use and intermittent use. In many traditional societies, particular drugs or formulations have been confined to medicinal use -- that is, to use under the supervision of a healer to alleviate mental or physical illness or distress. For several centuries after the technique for distilling alcoholic spirits had diffused from China through the Arab world to Europe, for instance, spirits-based drinks were regarded primarily as medicines (Wasson, 1984).

This way of framing drug use has been routinized in the modern state through a prescription system, with physicians writing the prescriptions and pharmacists filling them. Drugs included in the prescription system are usually forbidden for non-medical use.

Where a drug becomes a regular accompaniment of everyday life, its psychoactivity is often muted and even unnoticed, as is often the case for a habitual cigarette smoker. Likewise, in southern European wine cultures, wine is differentiated from intoxicating "alcohol"; wine drinkers are expected to maintain the same comportment after drinking as before. We may call this a pattern of "banalized use": a potentially powerful psychoactive agent is domesticated into a mundane article of daily life, available relatively freely on the consumer market.

Intermittent use -- for instance, on sacred occasions, at festivals, or only on weekends -- minimizes the build-up of tolerance to the drug. It is in the context of such patterns that the greatest attention is likely to be paid to the drug's psychoactive properties. The drug may be understood by both the user and others as having taken over control of the user's behavior, and thus to explain otherwise unexpected behavior, whether bad or good (see the "disinhibition hypothesis" in Peranen 1976; also Room and Collins, 1983). As in Stevenson's fable of Jekyll and Hyde, normal self-control is expected to return when the effects of the drug have worn off. Given the power attributed to the substance, access to it may be limited: in traditional societies, by sumptuary rules keyed to social differentiations; in industrial societies, by other forms of market restriction.

In industrial societies, a fourth pattern of use is commonly recognized for certain drugs: addicted or dependent use, marked by regular use, often of large doses. Since the pattern of use of the drug in question is not defined in the society as banalized, addiction is defined as an individual failing rather than as a social pattern. While attention is paid to physical factors sustaining regular use, such as use to relieve withdrawal symptoms, most formulations of addiction focus on psychological aspects, including an apparent commitment to drug use to the exclusion of other activities and despite default of major social roles. An addiction concept thus also focuses on loss of normal self-control, but the emphasis is not so much on the immediate effects of the drug as on a repeated or continuing pattern of an apparent inability to control or refrain from use, despite adverse consequences.

ADDICTION AS A MODERN GOVERNING IMAGE

The concept of addiction as an affliction of the habituated drug user first arose in its modern form for alcohol, as heavy drinking lost its banalized status in the United States and some other countries under the influence of the temperance movement of the nineteenth century (Levine, 1978; 1992). Habitual drunkenness had been viewed since the Middle Ages as a subclass of gluttony; now, abstinence from alcohol was singled out as a separate virtue, and as an important sign of the key virtue, in a democracy of autonomous citizens, of self-control. Along with other mental disorders, "chronic inebriety", as alcohol addiction was usually termed, was reinterpreted as a disease appropriate for medical intervention (although without losing all of its negative moral loading).

In nineteenth-century formulations, addictiveness was seen as an inherent property of alcohol, no matter who used it, and this perception justified efforts to prohibit its sale. By the late nineteenth century, such addiction concepts were being applied also to opiates and other drugs,

and this formulation has remained the governing image (Room, 1973) for these drugs to the present day. But as temperance thinking became unpopular with the repeal of national alcohol Prohibition in the U.S. (1933), for alcohol the concept was reformulated to be a property of the individual "alcoholic", mysteriously unable to drink like a normal drinker. This "disease concept of alcoholism" received its classic scholarly formulation by Jellinek (1952), although Jellinek (1960) later retreated to a broader formulation of alcohol problems.

In popular thinking and often in official definitions, addiction has remained a property of the drug for illicit drugs but of the person for alcohol (Christie and Bruun, 1968). The inherent addictiveness attributed to illicit drugs is the primary rationale for their prohibition. The extent of the anathema imposed in U.S. cultural politics by labeling a substance as "addictive" can be gauged from the unanimous testimony of cigarette company executives to the U.S. Congress in 1994 that they do not believe that cigarettes are addictive, despite the evidence of their own corporate research (Hilts, 1994).

In recent years, American philosophers have begun to question and rethink the meaning of addiction concepts (Szasz, 1985; Fingarette, 1988; Seeburger, 1993) and to consider the implications for drug policy (Husak, 1992). In a related initiative, economists have begun propounding and testing theories of "rational addiction" (Grossman, 1993). By the mid-1990s, this critical thinking had had no discernible influence on the American political consensus around an addiction-based policy for illicit drugs.

APPROACHES TO LIMITING THE PROBLEMS FROM DRUG USE

Most human societies have known of and used psychoactive drugs, and most have also made efforts to limit the use of one or more drugs, customarily if not legislatively. Historically, the main aim of restrictions was to diminish threats to the social order or to increase the labor supply. Public health concerns were sometimes expressed in justifying restrictions -- for instance in the efforts of James I of England to stem tobacco smoking (Austin, 1979) -- but such concerns were rarely decisive. The restrictions on the spirits market adopted in Britain as a response to the extreme alcoholization of eighteenth-century London (depicted in Hogarth's famous print of "Gin Lane") are an early example of limits substantially motivated by public health concerns (Coffey, 1966). Only in recent decades have public health concerns become a major element in discussions of drug policies, although the concerns are often subordinated for legal drugs to fiscal and economic considerations, and for illicit drugs to moral and lifestyle issues.

The health hazards from psychoactive drugs occur in two main ways: in connection with particular occasions of use, or in connection with the patterning of use over time. Thus an overdose from barbiturates, a traffic casualty from drunk driving, or an HIV infection from sharing a needle to inject heroin are all consequences associated with a particular occasion of use, while lung cancer from tobacco smoking, liver cirrhosis from alcohol use, and (by definition) addiction all reflect a history of heavy use (Room, 1985). As we shall note, measures to prevent event-related problems often differ from and may even conflict with measures to prevent cumulative, condition-related problems. For alcohol, the ethical situation with regard to public health measures is now complicated by the possibility of a protective effect on heart disease to be balanced against the undoubted negative health effects (Schmidt, 1985; Edwards et al., 1994).

Efforts to limit problems from drug use can be seen as oriented to controlling whether the

drug is used at all, to influencing the amount, context and pattern of use, or to preventing harmful consequences of use (Bruun, 1970; Moore and Gerstein, 1981).

(1) Prohibiting use to all or some. Efforts to impose a general prohibition on the use of a drug for all members of a society have a lengthy history, although the efforts have frequently ended in failure (Austin, 1979). Perhaps the most sustained such effort has been the prohibition on alcoholic beverages in Islamic societies. In general, religious taboos on drug use tend to have had more lasting effect than state prohibitions. Prohibiting the sale or use of a drug which some might choose to use and enjoy involves a degree of intervention in the marketplace and in private behavior unusual for modern democratic states. If there are those who use the drug without problems, the prohibition on their use must be justified as for the benefit of others who would have or cause problems if they used the drug. In societies with a strong tradition of individual liberties and consumer sovereignty, the discomfort with this line of argument in support of prohibition is commonly resolved by presumptions that users will sooner or later become addicted, and that users without problems do not really exist.

A common form of prohibition on use in village and tribal societies has been sumptuary rules restricting use to particular status groups, most commonly to the most powerful segments of the society. Depending on the culture, a variety of arguments are offered for the inability of lower-status groups to handle drug use appropriately. Since psychoactive drugs offer visions of an alternative reality (Stauffer, 1971), and may be associated with disinhibition, dominant groups may fear challenges to their power if subordinates have access to drugs (Morgan, 1983). The universalist ethic of modern states has made such explicit sumptuary restrictions untenable, with the substantial exception of prohibitions on use by children. Even the provisions, still common in U.S. state laws, that the names of habitual drunkards should be posted and that those listed should be refused service of alcoholic drinks are unenforced because of their perceived interference with individual liberties.

A third form of modified prohibition of use, much used in modern societies, is the limitation to medicinal use. The individual's supply of such medications is controlled by state-licensed professionals, backed up by a state system of market controls. National controls on psychopharmaceuticals are backed up by an unusual and elaborate international control structure (Bruun, Pan and Rexed, 1975; Nadelmann, 1990). In principle, prescription and use of the drugs is limited to therapeutic purposes. For psychoactive drugs, commonly prescribed to relieve negative affective states or mental distress, the leeway for what constitutes therapeutic use is often quite wide, and a substantial part of the resources of the health system in industrial societies is absorbed in superintending the provision of psychoactive drugs. Except for methadone as a remedy for heroin addiction and nicotine as a remedy for tobacco smoking, it is generally considered illegitimate to prescribe a drug in order to maintain a habitual pattern of use without withdrawal or other distress. Use for pleasure or for the sake of the psychoactive experience is considered nontherapeutic, so that the functions of drugs considered as psychopharmaceuticals are always described in terms of the relief of distress rather than of the provision of pleasure. To some extent, the medical prescription system in a modern state serves as a covert form of control by status differentiation, according to the prejudices of the prescriber: for instance, older and more respectable adults will find it easier than the younger and more disreputable to obtain a prescription for a psychopharmaceutical.

(2) Influencing the pattern of use. An enormous variety of strategies, formal and informal, have been used to influence the amount, pattern, and context of use of drugs. Among the potential aims of such strategies is the public health aim of reducing the prevalence of hazardous use.

(a) **Controlling availability.** One class of such strategies attempts to reduce drug-related problems by controlling the market in drugs, whether by taxes, by general restrictions on availability, or by user-specific restrictions (Room, 1984; Edwards et al., 1994). Public health considerations are one reason among several that governments tax legally available drugs like alcohol and tobacco. Such taxes often constitute a substantial portion of the price to the consumer. Raising taxes does diminish levels of use, among heavier as well as lighter users, although demand usually diminishes proportionately less than the proportional increase in price (i.e., is relatively inelastic). Thus, short of levels which create an opening for a substantial illicit market, raising taxes on drugs tends both to have positive public health effects and to increase government revenues.

Governments often also control the conditions of availability, particularly for alcohol. Through a system of retail licenses or by a government monopoly of sales, limits are placed on the hours and conditions of sale. Changes in these limits have sometimes been found to affect patterns of consumption and of alcohol-related problems (Smith, 1988). However, with the strengthening of the ideology of consumer sovereignty -- that legal goods should be readily available, with purchases limited only by the consumer's means -- controls on availability tend to have been loosened in recent decades (Mäkelä et al., 1981).

A generally stronger and more direct effect on hazardous alcohol consumption has been found from measures that ration or restrict the availability of alcohol for specific purchasers (Edwards et al., 1994). A general ration limit for all purchasers particularly restricts heavy consumption, or at least raises its effective price, but such measures strongly conflict with the ideology of consumer sovereignty, and are thus now politically impracticable nearly everywhere.

As noted above, proscriptions or limits on sales to named heavy users have also fallen out of favor as infringements on individual liberty.

(b) **Controlling the circumstances of use.** Another class of strategies aims to deter drinking or drug use in particularly hazardous circumstances, usually with criminal sanctions. The prototype situation here is driving after drinking. Given that alcohol consumption impairs vehicle driving ability, most countries now treat driving with a blood-alcohol level above a set limit as a criminal offense, and enforcement of these laws often absorbs a substantial part of the criminal justice system's resources. Popular movements as well as policymakers have expended much energy, particularly in the U.S. and other anglophone and Scandinavian countries, in seeking a redefinition of drunk driving as a serious rather than a "folk crime" (Gusfield, 1981). This type of situational limit or prohibition has been extended to other skill-related tasks, and has also been applied to driving after using other psychoactive drugs, particularly illicit drugs. A related development has sought to eliminate illicit drug use in working populations and alcohol use in the workplace by random urine testing of workers, with job loss as the sanction (Zimmer and Jacobs, 1992). The ethics of this measure, strongly pushed by the U.S. government in the 1980s, are controversial, particularly since the tests detect illicit drug use that has not necessarily affected work performance (Macdonald and Roman, 1994). Random blood-alcohol tests of drivers to deter

drinking-driving have also proved controversial; they are well accepted and widely applied in Australia (Homel et al., 1988), legally permissible but not intensively applied in the U.S., but viewed as an impermissible infringement on individual liberty and privacy in many countries.

(c) **Education and persuasion about use.** A third class of strategies seeks to educate or persuade against hazardous drug use. Since such strategies are seen as the least coercive, at least for those beyond school age, they are used very widely and commonly, despite the frequent lack of clear evidence on their effectiveness (Moskowitz, 1989). Some education of schoolchildren about the hazards of drug use is very widespread, indeed nearly ubiquitous in the U.S. Most countries in the world have also made at least a token effort at public information campaigns about the hazards of tobacco smoking, and poster and slogan campaigns against drinking-driving and against illicit drug use are also widespread. Other public information campaigns on alcohol have promoted limits on drinking (e.g., suggestions of safe levels in Britain and Australia) or campaigned against drinking in various hazardous circumstances. Often these public information campaigns compete for attention in a media environment saturated with advertising on behalf of use from tobacco or alcohol brands. In the last 20 years, some governments have imposed substantial restrictions on tobacco and (to a lesser extent) on alcohol advertising, for example, banning advertisements on electronic media, and requiring warning labels in advertisements or on product packages. These restrictions have often precipitated court fights over the constitutional permissibility of restrictions on the freedom of "commercial speech".

(3) Reducing the harm from use. The strategies considered so far are primarily directed at influencing the fact or pattern of use. They thus fall into the categories either of supply reduction or demand reduction, to use terminology commonly applied concerning illicit drugs. Since the late 1980s, substantial attention has been directed to a third option -- harm reduction; that is, strategies which reduce the problems associated with drug use without necessarily reducing the drug use itself (O'Hare et al., 1992; Heather et al., 1993). Attention to this class of strategies has a somewhat longer history for alcohol (Room, 1975). Usually, the strategies focus on the physical or social environment of drug use, seeking physical, temporal or cultural insulation of the drug use from harm. Thus, needle exchanges aim to remove the risk of HIV infection from injection drug use, and seat-belts and air-bags insulate drinking-drivers -- and those around them -- from potential casualties.

The debate over harm reduction strategies for illicit drugs has raised classic ethical issues for public health. Some argue that insulating the behavior from harm will encourage and thus increase the prevalence of the behavior. A further consideration is the actual effectiveness of the insulation provided. Thus, efforts to provide a safer tobacco cigarette have been largely undercut by compensatory changes in puffing and inhaling by smokers. At an empirical level, it seems that insulating drug use from harm does not necessarily increase the prevalence of drug use. Even if it did, an old public health tradition, epitomized by the operation of venereal disease clinics, would argue that reducing the immediate risk of harm takes a higher ethical priority than affecting the prevalence of disapproved behaviors.

THE POLITICAL REALITY IN THE MID-1990S: LOPSIDED POLICIES

The U.S., and many other countries also, have experienced recurring "moral panics" in recent decades concerning illicit drug use, and have invested very substantial resources in efforts

to prevent such use. These resources have been largely invested in two directions: a particular preventive strategy -- interdicting the illicit market -- and the provision of treatment. The first of these directions has received the greatest investment of government resources. There has indeed been a substantial decrease in illicit drug use in North America in the late 1980s and early 1990s (possibly due primarily to the normal ebb and flow of youth fashions), though data from 1993 and 1994 suggest that the decline may be ending. But the illicit market remains strong, while drug-related imprisonments have helped propel the U.S. to the highest rate of incarceration among industrial societies. Meanwhile, preventing the very substantial health harm from legal drugs like alcohol and tobacco has received a much lower priority. In government policymaking, public health considerations have often been subordinated to economic concerns. In recent years, for example, the U.S. has successfully attacked control structures and forced a greater availability of both alcohol and tobacco in other countries with suits under the General Agreement on Tariffs and Trade (Ferris et al., 1993).

A substantial emphasis on the treatment of addiction has accompanied the attention to prevention. But in this mixed policy environment, the role of treatment has been highly differentiated by type of drug. To a large extent, tobacco smoking has remained defined as a health rather than a social problem, with the emphasis on the health consequences of smoking rather than on the physical dependence of smokers on tobacco. Thus there has been very little public provision of treatment for smoking addiction; most of those who have quit have done it by themselves or in mutual-help groups. At the other extreme, the goals for an illicit drug treatment system have been highly ambitious: in theory, in the mid-1970s and again in the late 1980s, the U.S. aspired to provide treatment to every unincarcerated addict. Quite explicitly, treatment for illicit drug use has been seen as a form of social control, and a high degree of coercion to treatment has been taken for granted (Gerstein and Harwood, 1990). On occasion, U.S. drug strategies have argued for the provision of treatment as a means to encourage courts to be tougher on those who will then have chosen not to accept it (Strategy Council on Drug Abuse, 1973:38).

In the case of alcohol, there has also been a large growth in treatment provision, not only in the U.S. (Klingemann et al., 1992). But alcohol treatment in the U.S. was until recently less an adjunct of the criminal justice system, and it remains quite separate in other countries. The growth of alcohol treatment provision, it has been argued, accompanied and served as a "cultural alibi" for the dismantling of the alcohol control structure left behind by the temperance era (Mäkelä et al., 1981). Although there is an increasing contradiction between the demands for sobriety in a technological environment and the increased market availability of alcohol, managing this contradiction is seen as a character test for the individual consumer, with treatment for alcoholism provided for those deemed to have failed the test.

These policy trends for alcohol and tobacco apply in broad terms also to other industrial countries, although high-tax strategies have been more commonly applied outside the U.S., particularly for tobacco. For illicit drugs, the U.S. "drug war" ideology has been strongly exerted internationally as well as at home (Traver and Gaylord, 1992). Through such mechanisms as the international narcotics control conventions, and through active multilateral and bilateral diplomacy, the U.S. has been relatively successful in maintaining and indeed strengthening legal prohibitions. Nevertheless, the international illicit market continues to grow. In debates about drug policies in the mid-1990s, the practical relevance as well as the ethics of current U.S.

policies is now increasingly questioned by scholars (e.g., Graubard, 1992).

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