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## Breaking the Impasse in the War On Drugs: A Search for New Directions

Norman E. Zinberg M.D.\*

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Norman E. Zinberg M.D.

## **Abstract**

Although virtually all illicit drugs in use today have been available for many decades-Havelock Ellis experimented with and then recounted his use of psychedelics in Godey's Ladies Book in 1898-most people date the Drug Revolution from 1962.

**KEYWORDS:** war, drugs, illicit

## Breaking the Impasse in the War on Drugs: A Search for New Directions

Norman E. Zinberg, M.D.\*

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Although virtually all illicit drugs in use today have been available for many decades—Havelock Ellis experimented with and then recounted his use of psychedelics in *Godey's Ladies' Book* in 1898—most people date the Drug Revolution from 1962. Timothy Leary's cry of "Tune In, Turn On, and Drop Out" heralded the sixties and the use of acid. LSD (lysergic acid diethylamide) was used in the first wave of a vast social experiment with psychoactive drugs. By 1965, polls showed that illicit drug use was the greatest single concern of Americans, ahead of nuclear war, the brain drain, and the teacher shortage, and during that year was accorded as many front-page stories in *The New York Times* as any other topic.

One of Richard Nixon's first acts in office was to create the Special Action Office for Drug Abuse Prevention, which proclaimed the definitive War on Drugs. There was to be, first, an all-out attack on supply, including political pressure on exporting countries, and second, a build-up of treatment facilities to take care of the unfortunates "hooked" on such substances. Almost 25 years have passed since illicit drug use became "popular" and users have gone from being the repentant deviants of the twenties and thirties to enemy deviants, to use Joseph Gusfield's felicitous phrase. Enough time has elapsed, as this discussion will describe, to assess trends in the use and treatment of those in trouble, and to reflect on how what has gone on over the past 25 years and what has been learned can be brought to bear on current social policy.

Essentially, the vast social experiment has consisted of four waves of expanded use of some psychoactive drug. First, beginning in 1962, were the psychedelics, chiefly LSD. By 1965, white America discovered marijuana. Heroin took over from 1968 to 1972, and to everyone's surprise, in the mid-seventies cocaine use began to grow exponentially. During these periods, other drugs also experienced expanded use. For example, the use of amphetamines, which had been a problem because

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\* Clinical Professor of Psychiatry, Harvard Medical School.

they had been prescribed for dieting since the thirties, had a surge—as “speed”—in the late sixties; PCP—as “angel dust” or THC—reappeared briefly as a devil drug in the late seventies. Barbiturates, “ludes” (methaqualone), and later benzodiazepines, chiefly Valium—the “downers”—were always available. It should be remembered that those drugs other than the psychedelics, alcohol, marijuana, the opiates, and cocaine did not have a “good,” *i.e.*, highly pleasurable, reputation among users. The downers were known as “wallbangers” because users, when intoxicated, lost so much control that they banged themselves against objects. PCP was cheap, could be eaten, sniffed, or smoked, and was usually used only when other drugs were not available. As early as 1969, *Avatar*, a Boston underground newspaper, carried on its entire front page the headline, “Speed Kills.” Amphetamines are harsh and metabolically upsetting in heavy use.

These differentiations among drugs are far easier to recognize with the passage of time. When headlines screamed of the assaultive potential of PCP use, it was harder to think of such use as the passing fad that it was, not because of law enforcement prevention or treatment efforts, but because users didn’t much like the drug. In the throes of the sixties when LSD was thought to offer the hope of spiritual oneness with the universe and mystic insight or fear of permanent madness and disintegration, who would have imagined the “Oh, so that’s what is meant by a psychedelic color” response of a first-time user in 1973, after a decade of psychological preparation for the experience? There was virulence in the ideological struggle between the peaceniks, marijuana-using “heads,” and the patriotic, alcohol-using “juicers” in the late sixties and early seventies. Soon the mixing of alcohol use with other drug use became standard for all persuasions and social classes. The divergence between alcohol users and marijuana users allowed the choice of drug for a short time to have a political significance that seems a parody in the upper middle-class, Republican cocaine use of the early eighties.

Some increases in the use of such drugs as methaqualone or Valium seemed to be iatrogenically initiated. Before the decline of use in the last few years, Valium was the most prescribed drug in the pharmacopoeia. And methaqualone, despite a growing reputation in Europe and England as “heroin for lovers,” when introduced into the United States as a Schedule IV drug (little potential for abuse) led to an almost unprecedented onslaught of free samples to doctors. Then, once the dissemination of the drug took on other than medical uses, which could easily have been anticipated, its classification abruptly

shifted to Schedule I (no legitimate medical use), thus depriving the pharmacopoeia entirely of perhaps the safest, least hangover-producing, mild sedative.

One of the most remarkable aspects of this drug revolution was the speed with which it caught on with such huge numbers of people. It is hard to believe that by 1972 over 10 million people had tried a psychedelic drug, and over 50 million, marijuana. In the same year, the estimates of cocaine users were in the low thousands, too few to count. By now, however, more than 20 million Americans have tried cocaine. There have been major reductions in the use of some of these other substances along the way.

After 1973, psychedelic use dropped sharply until a recent minor upsurge in 1984 with the appearance of MDMA, "Ecstasy." But each wave of use of each drug has left a residue of more users than there were before. Following the heroin epidemic of 1968 to 1972 there was an enormous drop in use, but many estimates suggest—and this numbers game is a highly inaccurate one—that the addict population stabilized at about 500,000, perhaps double what it was before that surge of heroin use. Little is known about the influence of that surge of use on the existence of an unknown number (probably large) of occasional users, "chippers."

What has been learned about the effects of these drugs varies. Our knowledge of the physiological and pharmacological effects has increased phenomenally, but our increase in objective understanding of the psychological and emotional impact has been hampered by the climate of bias and prejudice by both users and opponents of use. The understanding of how to treat people in trouble, particularly with heroin and cocaine, has also increased dramatically, but more for social and economic reasons than because of prejudice against drug users—only a few get the best possible treatment.

One great change in our understanding over these years, which eventually should be reflected in social policy, is that while intoxicants differ from each other in many ways, the basis for estimating their danger and their effect cannot be simply whether one is legal and another not. An increased concern about drunk driving or, more properly, driving while intoxicated, shows that this dangerous practice usually, but certainly not exclusively, takes place under the influence of a licit drug. Oddly, as the extreme destructiveness of heavy cocaine use becomes increasingly apparent, the tendency of such users to build their use into their everyday, automatized behavior patterns for a lift is more like the use of cigarettes, which practice is physiologically most dangerous,

than it is like heroin, marijuana, or alcohol use.

During these twenty-five years, there have been marked changes in public attitudes toward various drug usage. Much money has been expended not only on peer-reviewed, data-based research, but also on learned commissions in both the United States and Canada intended to inform the public and initiate public policy reforms. As marijuana use spread rapidly among the youth of the nation in the late sixties and early seventies, its use was virtually institutionalized. For many students of the issue, the fact of its illicitness, with its aura of law-breaking, fear of police, and indeed, in far too many cases, actual incarceration, seemed more socially disruptive than the drug itself.

In the light of such opinions, the reports of the Shafer Commission in this country and the LeDain Commission in Canada called for decriminalization of marijuana. Decriminalization, many felt, was legally ambiguous, but by removing criminal penalties for the possession of small amounts for personal use while still punishing dealers harshly, it at least prevented young people from facing jail for something that was not seen by them as a crime. It also bought time for society and for the research community to evaluate further the long-term social, psychological, and physiological effects of marijuana, without taking a definitive stand toward moving marijuana from the illicit to the licit category. Twelve states passed some version or other of a decriminalization statute at that time.

That time was, after all, just after the peace movement had forced the end of the Vietnam war, when affirmative action seemed morally unambiguous, and the arguments about social justice were more about when, how, and how much, than about whether. Several things happened which shifted the social climate.

There was a marked conservative political shift in this country; cocaine use began to erupt; and most frightening of all, the age of first use of both licit and illicit drugs was dropping each year. By 1977 and 1978, the extent of the use of marijuana, alcohol, and some other substances, and the possibility that beginning use would move from the high schools to the junior high schools, led to more screaming headlines, more scare reports about the dangers of marijuana, the formation of mothers' groups against marijuana, and demands for stepped-up law-enforcement efforts not only within this country but at its borders and in the supplier nations. The talk at that time was of "gateway" drugs. "Gateway" was a new version of the old stepping-stone theory that claimed that users would begin use with a relatively soft drug like marijuana and gradually find that drug too weak, and proceed step by

step to stronger drugs, ending up inevitably with heroin. The gateway concept, which often, due to the newer enlightenment about all intoxicants included cigarettes and alcohol, more sophisticatedly insisted that once the barrier to any drug use is broken, gates are open making the use of any intoxicant socially and psychologically possible and even attractive.

One of the most powerful thrusts of the Shafer and LeDain Commissions, and later the 1978 President's Commission on Mental Health, had been to separate use from misuse. The Shafer Commission developed a five-point scale ranging from experimenters, who may have only tried marijuana, to chronic users. These commissions felt it was essential to take into account the quantity and quality of use if one were to understand the physical and psychological effects of that use on the user. The new gateway theory attempted to obliterate such thinking by claiming that any use opened up the way to misuse—the dogma of the fifties—and that, in fact, efforts to separate use from misuse were permissive and amounted to condoning drug use.

Mrs. Reagan has been a powerful proponent of the gateway theory and an advocate of the “new” war on drugs. Thus, there has been a sense that this position is our current social policy. Nevertheless, other factors create a more complex picture. Of all the learned commissions studying marijuana, the Relman Commission, which reported in 1982, was perhaps the most learned and certainly the most objective. While by no means “white-washing” the health effects of marijuana use, this group found most of the claims of its deleterious effects on health not proven and called for more research. Since 1979, the age of first use of any intoxicant has been consistently rising, and the general extent of use among young people is down. In fact, with the possible exception of cocaine, the use of intoxicants has stabilized or declined with some evidence that many of those who do use are more moderate or controlled in their use. For example, for the first time in the history of the United States, more light wine and beer have been sold than hard liquor during each of the last three years, with the curves widening. Combining this with the drop of proof in hard liquor from an average of 86 proof in 1975 to 80 proof today, it seems that more people are drinking but are drinking less. The curve of marijuana use shows that the preponderance has moved from the teens and early twenties to the 25- to 35-year-old group. Heroin use has declined somewhat. Prescriptions for Valium are down more than one-third. And even with cocaine, while the number of users seems to continue to grow slightly, there appears to be a change in the social class of user. The upper middle class,

which fueled those years of enormous growth, has seen too many casualties and has grown cautious. Other social classes are, unfortunately, still in the time of discovery, but if the cycle is as familiar as it now seems, there should soon be an overall drop in use. Two influential books by John Kaplan and by Arnold Trebach have, in the eighties, demolished the stepping-stone or gateway theory, just as so many researchers did in the sixties and seventies.

The new war on drugs also follows its familiar cycle. Large expenditures of money, new efforts to consolidate the forces, and new additions to those forces—a recent attempt to involve the armed services of the United States—have led to initial pronouncements of larger drug busts and assurances of eventual victory to a growing realization of impasse: a sad and predictable repetition.

Marijuana's bulk makes it easier to interdict, so most of the growing has moved to within the United States borders to an extent that it was recently announced as the largest cash crop in this country. Coca growers have learned to get at least one extra harvest per growing season, which more than makes up for the busts. This is not to say that this struggle against drug trafficking does nothing. In the Kaplan book mentioned earlier, this eminent legal scholar goes over every possible alternative policy relating to heroin and finds them all equally unsatisfactory.

At this time in this particular emotional climate, few major changes seem possible, but some minor, reasonable changes may be possible that may shift the balance of the impasse. First, it is again time to reconsider the question of marijuana. In the states where it was decriminalized, use patterns are no different from those in other states, and in one, Oregon, there has been a greater reduction in use than in most others. Not only would federal decriminalization of marijuana save money in law enforcement and reduce the load in our courts, but it would also help with the forthcoming civil rights struggle over urine testing. It is important to remember that there is no test for marijuana intoxication. Urine testing, which is notoriously inaccurate, can detect metabolic remnants of the cannabis molecule and give a positive result as long as two weeks after use. As I pointed out earlier, decriminalization commits society to little. In some ways this reduction in criminalization may make it easier to enforce certain restrictions, for example, on age, while we watch the results of marijuana legalization in countries like the Netherlands. At the same time, the United States can continue to invest in our own long-term social, psychological, and physiological research, as recommended by the Relman Commission. 6



Second, it is time to make heroin available for the terminally ill patient. Research shows that most terminally ill patients—at least 80 percent—do well on morphine or other opiate derivatives for their chronic pain. But a sizable fraction do better on heroin, and as the National Committee on the Treatment of Intractable Pain tirelessly points out, that horribly ill group should not be penalized by our current social policy.

Third, medical education at both the undergraduate and continuing education levels must be taught so that these professionals can learn more about the drugs they prescribe and the ones that people take outside a medical regimen. Even with alcohol, physicians and other health professionals know far too little. Few incidents are repeated more often or are more disappointing than for the family of a denying alcoholic to persuade him/her to go to the doctor for a “checkup” and have the doctor miss the alcohol problem. If doctors were more aware and more sophisticated, they might be more active in decisions about drug scheduling which might change several of them.

None of these changes are enormous in themselves. Their import is to alter the climate of interest around these drugs from a war mentality to more rational considerations. If it can be shown that drugs are being thought about for their actual impact—and marijuana is different from cocaine and heroin—or their actual use—and giving heroin for terminal illness is different from giving it to junkies—then an informed medical professional and an informed public may look at this vast social experiment of the last twenty-five years and recognize what can or cannot actually be tolerated within our social fabric. Only when people can trust the information they receive will they themselves separate which intoxicants can be used and which cannot. It is that capacity that is necessary to break the impasse.