Is recreational drug use normal?

THOMAS NICHOLSON, DAVID F. DUNCAN and JOHN B. WHITE

1 Professor of Public Health, Western Kentucky University, USA
2 Clinical Associate Professor of Medical Science, Brown University, USA
3 Associate Professor of Public Health, Western Kentucky University, USA

The purpose of this paper is to define drug use and differentiate this behaviour from drug abuse. We argue that one fundamental principle of the War on Drugs, namely that all use of illicit drugs is harmful and must be prohibited, is invalid. Statistically, clinically, and socioculturally, drug use is normal behavior. Current drug policy is based on the flawed premise that any use of illicit drugs is unhealthy. A public health model emphasizing demand reduction (as opposed to supply reduction), individual freedom, reason, and tolerance is recommended.

Keywords: drug use; normal behavior; recreational drugs

INTRODUCTION

American society focuses a tremendous amount of energy and resources on drug-related issues. The federal government has conducted a 'War on Drugs', spending billions of dollars on law enforcement programmes alone (American Public Health Association (APHA) 1992, Office of National Drug Control Policy (ONDCP) 2001). All levels of government from local to national, focus substantial resources on education, law enforcement, regulation and safety issues related to drugs. Also, the political arena has been a major area for the publicizing and politicizing of drug issues. At the same time, alcohol, tobacco, prescription, and over-the-counter drug producers are multibillion-dollar industries that serve the majority of Americans and play a major role in our nation's commerce. The illegal drug trade is a massive underground business, estimated at US$150 billion in retail sales (The Economist 2001), which permeates both public and private aspects of society. When the entire spectrum of psychoactive drugs (i.e. generally illicit substances such as marijuana, cocaine, etc., and predominantly licit substances such as alcohol, tobacco, certain prescription and OTC medications, xanthenes in soda, coffee, tea, and chocolate, unregulated herbal compounds, etc.) is taken into consideration, most Americans do or have in the past consumed psychoactive substances. Given these realities, it is imperative that we as a society understand our use of and behaviours connected with drugs. This paper will attempt to address a fundamental component of these issues, namely, is recreational psychoactive drug taking normal behaviour?

DEFINITION OF USE

Critical to this discussion is an understanding of what recreational psychoactive drug use is and is not. Drug consumption can be categorized into the areas of drug use and drug abuse. Drug use has been defined as taking a drug in such a manner that sought-for effects are attained with minimal hazard. If Mary Doe (an adult) consumes a martini with her Sunday dinner, this is an example of drug use. Drug abuse is taking a drug to such an extent that it greatly increases the danger or impairs the ability of the individual to function adequately or cope with their circumstances. If Mary Doe drinks so many martinis at dinner time every evening that she passes out at the table, her meal unfinished, having argued with her husband and frightened her children, then this would be drug abuse. Physiological dependence occurs with the regular consumption of certain drugs. Abrupt cessation leads to a withdrawal syndrome. This may or may not imply abuse or dependence in the behavioural sense (Irwin 1973, Glantz 1992, Institute of Medicine (IOM) 1994). By definition, then, the negative health consequences of drug consumption are the result of the abuse of these substances, not of their use.

A very important but seldom discussed fact about drug consumption in America is that most is use not abuse, with the exception of tobacco smokers – the majority of whom are abusers (i.e. they smoke at levels that substantially increase their risk of negative health consequences). One of the present authors has previously estimated that only 10–20% of all illicit drug takers develop a problem of abuse (Duncan and Gold 1983, Duncan and Petosa 1994).
Evidence from the Epidemiologic Catchment Area Study (Anthony and Helzer 1991) has revealed the more precise figure that 20.27% of all users of illicit drugs have experienced a period of abuse at some time during their drug use history. The prevalence of current drug abuse or dependence among persons who reported illicit drug use was 4.19%. The first symptoms of drug abuse typically occurred within 2–3 years after beginning illicit drug use and the median duration of a case of drug abuse/dependence was 4–5 years. Our discussion is focused on the entire spectrum of licit and illicit psychoactive drug use and assumes that drug abuse is abnormal by various criteria.

**INDIVIDUAL DRUG CONSUMPTION**

Psychoactive drug consumption is part of human history. Written records from throughout our past and across the planet attest to the consistent use of these substances (Heiman 1960, Steward 1967, Snyder 1970, The Holy Bible 1983, Musto 1989, Weil and Rosen 1993). An assortment of drugs have been consumed for a variety of reasons – recreational, therapeutic, artistic, and religious – over thousands of years.

Currently most, if not all, Americans consume psychoactive drugs in one form or another (Duncan and Gold 1982). The National Household Survey on Drug Abuse (NHSDA) (2000) reported that an estimated 14.8 million Americans were current users of illicit drugs. Among youths aged 12–17, 10.9% reported current use of illicit drugs. Given usage rates over the last several decades this means tens of millions of Americans have tried an illicit substance. The NHSDA also estimated 66.8 million Americans currently use some form of tobacco and calculated a prevalence rate of 30.2% nationwide in the population aged 12 years and older. This survey also found that 105 million Americans aged 12 years and older had used alcohol at least once in the 30 days prior to the interview. No recent prevalence figures exist for the use of caffeine or other unrecognized drugs, but between coffee, tea, cola, and chocolate, experience with caffeine must be nearly universal. Millions of Americans take legally prescribed psychoactive drugs such as narcotics to relieve pain, and tranquilizers to manage anxiety. How many American adults have never taken an over-the-counter or prescription drug, never consumed beer, coffee, or cola, never smoked a tobacco cigarette or a marijuana ‘joint’, nor consumed any of the myriad other drugs that are so plentiful in modern society?

Research by the federal government and others indicates that a large number of American adolescents consume illicit drugs. Evidence also indicates that young Americans use more drugs than adolescents in other developed countries (National Institute on Drug Abuse (NIDA) 1998). Of the millions of adolescents who experiment with or use drugs, however, the overwhelming majority go on to adulthood without a drug abuse problem (The Drug Abuse Council 1980).

**WHY DO PEOPLE TAKE PSYCHOACTIVE DRUGS?**

What motivates people to consume drugs? There have been numerous theories proposed to explain drug use as psychopathology. Broader motivational theories have been less common and less fully developed. Weil and Rosen (1993) state the basic reason people take drugs is to vary their conscious experience. They go on to list the following specific motivations

1. to aid religious practices
2. to alter moods
3. to treat disease
4. to escape boredom and despair
5. to promote and enhance social interaction
6. to enhance sensory experience and pleasure
7. to stimulate artistic creativity and performance
8. to improve physical performance
9. to rebel
10. to go along with peer pressure
11. to establish an identity; and
12. purely out of habit.

Ray and Ksir (1993) sum the matter up by stating that people consume drugs to reduce pain or increase pleasure. Cohen (1971, p. 71) expresses the same concept somewhat differently when he states the following principle: ‘People use drugs to “feel better” or to “get high”. Individuals experiment with drugs out of curiosity or hope that using drugs can make them feel better’.

Cohen (1971) and Dohner (1972), in papers published a year apart, with each citing the other’s earlier work, proposed similar lists of motives for illicit drug use. Cohen’s typology has been the more widely used of the two. Cohen described eleven motives for drug use, as follows:

- Physical, including relaxation, stimulation and relief from sickness
- Sensory, to magnify the senses
- Emotional, to relieve negative mood states
- Interpersonal, which included use to gain peer acceptance or to defy authority figures, as well as to break down communications barriers or to cement relationships
- Social, including both promotion of social change and tuning out intolerable social situations
- Political, to express political protest
- Intellectual, to escape mental boredom or to achieve new insights or solve problems
- Creative–Aesthetic, to enhance creativity or enjoyment of the arts
• Philosophical, to achieve insight into the meaning of life or other philosophical questions
• Spiritual–Mystical, to attain transcendence or enlightenment; and
• Miscellaneous, including adventure, risk seeking, drama or ‘kicks’.

This typology was tested by Bowker (1977) who concluded it was valid, but Cohen's theory has not been tested since.

Looking back over the preceding comments, it is apparent that the potential reasons for using drugs are just about as diverse as the total range of motivations for all human behaviour. Drugs are not used for unique reasons specific only to drugs, nor are they used predominantly for pathological reasons. They are used by different persons for different reasons and by the same person for different reasons at different times. Goines beyond this idea. Siegal (1989) argued that there is an innate drive in all human beings to use drugs. Weil (1972) may have been closer to the point in arguing that humans have a biological need to alter consciousness. Drugs, in the context of this view, are but one of the many means to satisfy this need.

THE CONCEPT OF NORMALITY AND DRUG USE

What is normal human behaviour? What characteristics distinguish normal from abnormal behaviour? The concept of normality is not easy to define. Normality can be described as that which is accepted as the usual and must be regarded as within a range. Normality can be viewed from several viewpoints—statistical, clinical, moral, legal, personal (i.e. subjective), and socio-cultural.

Statistical normality is simply those behaviours in which a majority of people engage. From the standpoint of a normal curve model, normal behaviour would cluster around the mean while abnormal behaviour would be two or more standard deviations away from the mean. Since most adults and adolescents use psychoactive drugs, ‘drug use’ is statistically normal behaviour. Drug abuse or a complete absence of drug-taking behaviour is statistically abnormal. Indeed, the non-user may be ‘deviant’ in the purely statistical sense. It may well be that the primary question among youth presented with the opportunity for experimentation is no longer ‘Why?’, but ‘Why not?’ (Cohen 1971).

If one separates legal and illegal consumption, a somewhat different picture emerges. Illegal drug usage rates are lower than the use of legal drugs. However, tens of millions of Americans have experimented with and/or occasionally use illegal drugs. The lifetime prevalence of this illicit drug consumption is 35.8% (Substance Abuse and Mental Health Services Administration (SAMHSA) 1999). Thus, at minimum, a substantial minority of Americans use or have used these drugs. Sarason and Sarason (1993, p. 5) noted ‘deviant or unusual behavior is not necessarily maladaptive’. A limitation of this perspective relates to our evaluation or judgements about either statistical normality or abnormal behaviour. A lone Jew living in a predominantly Christian community would be a statistical abnormality. However, no rational analysis would consider the Jewish individual behaviourally deviant or abnormal. Conversely, leprosy would be statistically normal among residents of a leprosarium. Again, however, leprosy is still not a desired condition.

Clinical abnormality would be those behaviours, disorders or syndromes that health professionals classify as exhibiting pathology or disease. Examples would include pneumonia, cancer, bipolar disorder and schizophrenia. For drug-taking behaviour the criteria for clinical abnormality would be those for Substance Abuse Disorder or Substance Dependence Disorder as specified in the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders, 4th edition (1994) – commonly known as DSM-IV.

According to DSM-IV, ‘the essential feature of Substance Abuse is a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances’ (American Psychiatric Association 1994, p. 182). The criteria for the disorder are that recurrent use of the drug has resulted in at least one of the following: failure to fulfill major role obligations at work, school or home; use in situations in which it is physically hazardous; repeated legal problems; or persistent social or interpersonal difficulties.

The essential feature of Substance Dependence is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems’ (p. 176). The diagnosis may be applied when three or more of the following criteria are met: tolerance; withdrawal; loss of control; persistent desire to or inability to cut down; a great deal of time spent obtaining, using and recovering from effects of the drug; giving up other activities in order to use the drug; and continued use despite physical or psychological problems caused by use. The mild, occasional or recreational use of drugs, whether legal or illegal, clearly does not meet these criteria of clinical abnormality. DSM-IV, in fact, explicitly states that, ‘Substance-Related Disorders are distinguished from nonpathological substance use ... by the presence of tolerance, withdrawal, compulsive use, or substance-related problems’ (p. 190).

Reneau et al. (2000) explored the mental well-being of a sample of occasional, recreational adult drug users via the DRUGNET survey on the World Wide Web. Mental health was assessed utilizing the General Well-being Schedule (GWBS). The DRUGNET sample’s (n = 906) mean score was 79.37 as compared with a mean of 80.30 from a representative sample (n = 6931) of non-institutionalized American adults in the Health and Nutrition Examination Survey-I (Fazio 1977). Reneau
Nicholson et al. (2000) also reviewed the GWBS score distribution and subscale scores and concluded that there was no observed difference between the overall mental well-being of the sample of recreational drug users and the general population norms.

In related, but different contexts, the fear of addiction and dependence has led to the under-prescribing of medications for effective pain management, especially for terminally ill and elderly patients. Medical marijuana initiatives are spreading across the USA as people with AIDS, cancer and other serious, often life-threatening, diseases seek more effective therapies.

Moral normality is concerned with the principle of right and wrong in relation to human action and character. Moral growth and development occurs from a myriad sources, both formal (e.g. family, school, government, and organized religion) and ordinary life experiences. There is a significant amount of variation across and within the many cultures of humankind. Many individuals view drug consumption, particularly of alcohol, tobacco and illegal drugs, as morally wrong, owing to their philosophical, spiritual, or religious beliefs. Their religious dogma, for example, may classify this behaviour as a sin and against the will of God. By contrast, the use of hallucinogens by some Native American communities is seen as part of their spiritual world. On the other hand, many others see drug use as behaviour that is not a moral issue but rather a matter of individual choice or as a morally acceptable choice.

Legal normality relates to the status of a behaviour in relation to the judicial system. Anything illegal is abnormal while all legal behaviours are normal. The distribution or possession of illegal drugs and the distribution of alcohol and tobacco to minors are thus legally abnormal, whereas the possession of or distribution to adults of alcohol and tobacco are legal and normal under most circumstances. Exceptions to this would include drinking and driving and smoking tobacco in legally prohibited areas. Possible advantages of this definition include the clear, publicly stated laws that people know about and can choose to obey. Cliftord (1992) and Jonas (1997) argued, however, that drug law enforcement varies across America contributing to increased negative consequences of drug abuse among ethnic and racial minorities. For example, the enforcement of laws relating to illicit drugs varies by socioeconomic status, with poorer users more likely to enter the legal system. These users also have fewer resources to defend themselves once in this system. People of colour in the USA are disproportionately represented in lower socioeconomic levels. Indeed, 80% of all drug users in the USA are white, but half of all individuals imprisoned for drug offenses are African American (Hoelter 1992). Large numbers of minority users and low-level distributors are incarcerated. According to the United States Department of Justice, "Among the more than 1.96 million offenders incarcerated on June 30, 2001, an estimated 608,000 were black males between the ages of 20 and 30..." (Beck et al. 2002, p. 12). High-level organizers, who are mostly white, have a lower rate of arrest and incarceration. 'Black non-Hispanics were 5 times more likely than white non-Hispanics, over 2½ times more likely than Hispanics, and 11 times more likely than persons of other races to have been in jail' (Beck et al. 2002, p. 12).

Another limitation of the legal model is variation over time and across states and localities. All the currently illegal drugs were legal at one time and alcohol was illegal during Prohibition. While alcohol is considered legal today for adults, it is still illegal commerce in 406 dry counties across 15 states and on numerous Native American reservations. This local prohibition, however, has contributed to long-standing bootlegging or illegal commerce in these areas and has been of questionable value in preventing alcohol use or abuse (Wilson and Nicholson 1989). Many localities prohibit alcohol sales on Sundays. Thus, what is normal on Saturday is not normal on Sunday. Also, internationally, drug laws vary widely. Marijuana has de facto legalization in the Netherlands and alcohol is banned throughout most of the Islamic world.

A further complication of the usefulness of legal normality in relation to drugs is their overall classification and history. All of these drugs, legal and illegal alike, have potent central nervous system effects and, if abused, can produce deleterious effects on the body. Their legal status is thus not based on their pharmacological effects nor on their potential for harm. For example, in the USA, tobacco kills hundreds of thousands of people each year while marijuana has yet to be directly linked to a single death. This reality is not surprising given the history of drug laws in the USA. Many of these laws were passed because of hysteria and politicization. Past beliefs included that certain drugs were being predominately used by ethnic and racial minorities and that the use of these drugs posed a threat to middle- and upper-class, white Americans (Cliftord 1992). It has been argued that marijuana was outlawed during the depression to legitimize harassment of Mexicans who were competing for jobs; opium and heroin to poison the Chinese; cocaine as a tool against African Americans; and LSD against youth, especially college students during the Vietnam War era (Helmer and Vierotisz 1974, Duncan and Rheinboldt 1980, Duncan and Gold 1982, Hoelter 1992).

The majority of Americans have accepted these laws as normal and common sense approaches to the nation's drug problems. Unfortunately, the public is woefully ignorant about facts concerning drug use and abuse. They have been told: (a) the consumption of recreational, psychoactive drugs (excluding alcohol and tobacco) is always harmful (i.e. all use is abuse); (b) society suffers an inordinate burden from the 'use' of these substances; and (c) laws and law enforcement programmes can effectively eliminate their production, distribution and consumption. All of which, to date, have been demonstrated to be false.

Additional authors have noted the many negative side effects of repressive drug laws (Duncan and Gold 1982, Nadelmann 1992, National Association for Public Health
Policy (NAPHP) 1999, Network of Reform Groups (NRG) 1999, Montagne (1992) for example, argues international drug-trafficking reduction efforts have contributed to crime, violence, loss of life, corruption of public and police officials, disruption of economic development, damage to ecosystems, conflicts between countries and destabilization of social, political and judicial systems. In a similar vein, Smart (1992) argued the economic function of prohibition is to stimulate production in the illicit drug industry. The effect of all these activities on the price of illegal drugs is spectacular. The war on drugs therefore functions, in practical fact, as a price support programme for the enrichment of drug industrialists. George Will, a noted conservative essayist, wrote ‘Will the United States ever learn? As long as it has a $50 billion annual demand for an easily smuggled substance made in poor nations, the demand will be served’ (Wall 2000b, p. B7).

Illogical inconsistencies also exist in drug laws when looking across different categories of drugs. Illicit drugs are primarily handled through law enforcement (i.e. supply reduction) and the judicial system (e.g. asset forfeiture, prisons, etc.). The majority of the White House’s ONDCP (2001) budget goes to these areas. Alcohol and tobacco policies emphasize regulation and taxation. Legal strategies concerning them are much more narrowly focused (e.g. prohibitions against under-age sales and public usage, smoke-free areas, driving-under-the-influence laws, etc.). Prescription psychoactive drugs are classified into various schedule categories by the United States Department of Justice, which also prosecutes illegal trafficking of these substances, and are regulated by the Food and Drug Administration for medical use. Unrecognized drugs like caffeine go largely ignored. These major administrative and policy inconsistencies contribute to the confusion of the public, the unequal treatment of people who use different drugs, and failed efforts to lower rates of ‘abuse’.

Illicit drug laws are therefore based on false premises about human behaviour and social dynamics. They have been demonstrated to be ineffective in reducing drug abuse and actually create additional problems. The usefulness of legal normality in relation to drug consumption is clearly invalid given the circumstances in America today.

Socio-cultural morality relates to the prevailing values, beliefs and activities in a given society. Again, these dynamics vary over time and across cultures. Legal drug use is widespread and big business in America. It is undeniably normal. Less widely used, but not uncommon, are illegal drug consumption and trade. Thus, one could conclude that American culture overtly accepts the use of some drugs as normal and others as abnormal. Covertly, however, the use of currently illegal drugs is an acceptable behaviour for a substantial segment of society. Thus drug consumption is pervasive and it is logical to conclude that drug use is a normative part of American culture.

A final variation relates to an individual’s personal view or definition of normality. Each person through the assessment of the aforementioned variations of normality, combined with their own life experience and perspective, is free to decide if drug use is normal. Americans are dedicated to life, liberty and the pursuit of happiness. We are free to think what we wish, and we generally have the freedom of speech to express it. Apparently, most Americans view some amount and types of drug use as normal. Many, perhaps a majority, view illegal drug use as abnormal, while a notable minority views all drug use as normal. Government efforts to prevent drug use may lack credibility for these recreational drug users who view drug use as normal. If so, this has significant policy implications.

For many individuals rationality is a key component of their personal belief system. Many, if not most, life experiences require a rational, reasoning and cohesive thought process for effective functioning. What will I do today? How do I drive the car? Where and how will I live? These are examples of the limitless number of issues that humans confront daily. Thus, many individuals think anything that disrupts rationality, such as drugs, reduces our functioning capacity and should be avoided. Other individuals, however, take a modified view of this. While agreeing that life requires rational thinking most of the time, they argue it does not require it all of the time. Humans engage in many leisure, recreational or other enjoyable activities mostly for the purpose of pleasure. Indeed the occasional recreational experience and/or temporary loss of rationality quite possibly helps us become more efficient and effective when we do need to function rationally.

**DRUG USE AND MENTAL ILLNESS**

In a classic paper, Zinberg and Lewis (1964) first made the heretical suggestion that the spectrum of heroin consumption includes persons who regularly use narcotics and develop little or no tolerance for them nor do they suffer withdrawal symptoms. Subsequently, Powell (1973) documented 12 cases of occasional heroin users or chippers. Zinberg and Jacobson (1976) identified another 54 such controlled or stable users of heroin and described five of their case histories. There were a variety of patterns of drug use among the 54 users, with some confining their use to weekends, two taking opiates more often and with variability in two cases. In four cases the current level appeared to represent a reduction from previous heavier usage – in two cases the reduction appeared to be associated with getting married. Numerous other studies have documented this hidden population of users (Scher 1961, Cohen 1989, Erikson 1989, Waldorf et al. 1991). Nicholson et al. (1999) in the largest of such studies to date, provide a broad demographic and behavioral profile of a sample of drug users. Nine hundred and six self-described “happy, successful adults with stable home lives who occasionally use drugs” completed a survey via the WWW. The typical respondent was male, well educated, employed, had
above-average income and was involved in community activities. Their self-reported drug consumption was controlled and at mild to moderate levels in both frequency of use and level of intoxication.

A few years ago, Shedler and Block (1990) astonished many readers with the findings reported in their study of 'Adolescent drug use and psychological health'. They reported on a longitudinal study which had followed a cohort of 101 subjects from the age of 3 until age 18 – with assessments at ages 3, 4, 5, 7, 11, 14, and 18. Based on a drug use assessment conducted at age 18, the subjects were classified as abstainers, experimenters, or frequent drug users. Consistent with societal expectations, they found the frequent users, as a group, to be abnormal. Frequent users were found to be 'relatively insecure, unable to form healthy relationships, and emotionally distressed as children' (Shedler and Block 1990, p. 624). Furthermore, these characteristics were found to have preceded their use of drugs. In other words, it appeared that emotional problems predisposed adolescents to become frequent drug users, rather than frequent drug use causing emotional problems.

Contrary to what most Americans would expect, however, they found that abstainers were also emotionally disturbed. Abstaining adolescents were found to be 'anxious, emotionally constricted, and lacking in social skills' (Shedler and Block 1990, p. 624). The relationship they had found between psychological health and drug use was curvilinear – both abstainers and frequent users showed poor health while experimenters were relatively healthy. They were led to conclude that, 'In the case of experimenters, drug use appears to reflect age-appropriate and developmentally understandable experimentation' (Shedler and Block 1990, p. 627).

Clifford et al. (1991) found a similar curvilinear relationship between illicit drug use and life satisfaction in a sample of college students. Less satisfaction with their lives was found among both abstainers and heavy drug users, while greater satisfaction was associated with moderate levels of illicit drug use.

A major longitudinal study by Newcomb and Bentler (1988) has followed a cohort of students for 12 years following their initial identification as junior high school students in Los Angeles public schools. They reported that adolescent drug use predicted self-reported physical health problems in young adulthood but was not related to impaired mental health. In a further analysis of the same data, Castro et al. (1988) found that, when full statistical controls were applied, heavy cocaine use in adolescence was modestly predictive of depression, impaired motivation and physical health problems in young adulthood.

In the most detailed analysis of this data, Newcomb et al. (1994) found no association between adolescent poly-drug use and any of 77 measures of mental disorder used in their study. Those subjects who had increased their poly-drug use between the adolescent and young adult assessments, however, showed greater levels of psychoticism and suicidal ideation as adults. In general, they found that, 'substance use as a teenager had few long-term detrimental effects on mental health functioning' (Newcomb et al. 1994, p. 233).

**DISCUSSION AND CONCLUSIONS**

The answer to our question, 'Is recreational use of drugs normal?' is not a simple one. Statistically, clinically and socio-culturally the use of psychoactive drugs is clearly normal behaviour. Morally and personally, there are certain types of drug use that would be classified normal by some and abnormal by others. Legally, some drug use is normal and some is abnormal.

How are we as a society to respond to these realities? One possibility, which has been receiving increasing support, is the application of a public health model to drug policy (Dee Jarlais, 2000; NRG 1999, NAPHP 1999, Nadelmann 1992). Public health approaches are geared toward the prevention of disease and the promotion of health and wellness. Drug abuse creates significant health hazards to the individual and society contributing to physical disease, psychological problems and social maladaptations. As such, public drug abuse prevention, education, and treatment should receive significantly more attention and resources. Drug use with little or no risk to individuals or society does not require ameliorative efforts. Most individuals can and do use drugs responsibly, maintaining a balance between individual freedom and social/personal responsibility. An increase in consistency of policies across categories of drugs would also be beneficial. Appropriate regulation, taxation, education, treatment, prevention, and law enforcement strategies should be applied to drugs in logical and consistent ways.

Critics of drug reform ideas often argue that if currently illicit drugs were somehow legalized or decriminalized there would be a large increase in their utilization with concomitant harmful results (e.g. addiction, disease, death). There are no data to support this assertion. However, historical evidence suggests this is not true. Prior to 1914, most of the currently illicit drugs were legally consumed in the USA America, from its discovery until 1900 did not experience widespread or rampant drug abuse. More recently, the decriminalization of marijuana in numerous states, did not lead to widespread use. Further, de facto legalization of marijuana in the Netherlands has not adversely affected the health of that nation. In fact, they consume marijuana at a lower rate than Americans. Recent 'drug prohibition' has simply driven drug distribution into illegal black markets run by organized criminals. The notion that decriminalization or legalization would make these drugs more accessible is simply not true. Access is there for anyone who wants the drugs now. Prohibition merely means that the controls are in the hands of criminals instead of governments.

An asset of American society is that we need not all agree
on personal lifestyle choices. A balance is achievable between individual freedom and a person's responsibilities to society. For example, an adult can choose to drink or not to drink alcohol while accepting the responsibility to not drink and drive. And minority points of view (i.e. Judaism, Agnosticism, Christian Fundamentalism, etc.), behaviours (i.e. playing golf, driving a sports car, painting watercolours, etc.), or life circumstances (i.e. being handicapped, rich, gay/lesbian, etc.), can be tolerated. Subjective or personal morality is very important to the individual as they attempt to live and deal with life's issues on their own terms. For example, if an individual believes that the use of drugs is wrong, they have the right and freedom not to consume them. Imposing one's personal view of drug use on society, however, is not practical or even feasible given the diversity of opinions. As John Stuart Mill (1956 [1887], p. 13) wrote: “The only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others . . . . Over himself, over his own body and mind, the individual is sovereign.” Given the high level of misinformation concerning drug behaviour underlying many individual perspectives and government policies, such an imposition is also not desirable. Unfortunately, the increasing criminalization, starting with the Harrison Act of 1914, and politicization of drug policy in North America has come from special interest groups and powerful individuals bent on implementing personal agendas (e.g. Harry Anslinger, Richard Nixon, Nelson Rockefeller) (Blumenson and Nislen 1998, Keys and Gallaher 2000).

As was previously discussed, the idea of rationality deserves more serious consideration. Certainly, human existence is difficult. Life grounded in reason and responsibility offers a better chance for effective living and happiness. However, a 100% rational existence is neither feasible nor desirable.

We as a society need to discuss and explore the questions posed by this article more deeply. America suffers substantial negative social, health, and economic consequences from drug abuse itself and our attempts to prevent illicit drug consumption. It is apparent that past and present policies have not effectively dealt with our drug problems and are in fact contributing to them. At the heart of many of these policies, laws, and programmes has been the notion that all consumption of illicit drugs is abnormal. This assumption is invalid and thus any policy grounded in it is likely to be ineffective. Meanwhile, prevention efforts against the abuse of legal drugs has received much less attention from the government producing less than desired outcomes. Current effective harm reduction programmes targeted toward alcohol/tobacco consumption (e.g. limits on public smoking, safe driving educational campaigns, etc.) could be expanded and also focused on the currently illicit drugs (e.g. making hospital emergency rooms arrest-free zones). Two-thirds of the US federal government’s $20 billion war on drugs budget goes to largely ineffective criminal justice supply reduction efforts. Monies could be re-targeted to effective harm reduction strategies such as primary prevention and treatment.

Drug use is clinically and statistically normal behaviour. Individuals can choose whether to engage in this behaviour and most consume drugs in a responsible way. A drug-free society is not a feasible possibility. Or as Michael Oakshott, cited by Will (2000a), stated “To try to do something which is inherently impossible is always a corrupting experience.” Currently millions of individuals suffer from the burden of drug abuse or the negative side effects of prohibition (e.g. The War on Drugs). For a society grounded in individual freedom, current drug policies are maladaptive and in dire need of revision.

REFERENCES

8 Nicholson et al.


