Recurring Epidemics of Pharmaceutical Drug Abuse in America: Time for an All-Drug Strategy

Observers describe today's "epidemic" of pharmaceutical drug abuse as a recent phenomenon, but we argue that it is only the most recent of three waves stretching back more than a century.

During each wave, policies have followed a similar pattern: voluntary educational campaigns, followed by supply-side policing and—sometimes—public health responses that would today be understood as "harm reduction."

These experiences suggest that only broad-based application of all three approaches to users of all drugs (not just pharmaceutical drugs) can produce a reduction in drug-related harm rather than merely shifting it from one type of drug to another. This has rarely happened because policy has been shaped by the racially charged division of drug users into deserving and morally salvageable victims, or fearsome and morally repugnant criminals. (*Am J Public Health*. 2016;106:408–410. doi: 10.2105/AJPH.2015.302982)

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According to the Centers for Disease Control and Prevention, prescription drug abuse has reached "epidemic" proportions; deaths from prescription drugs, particularly opioid analgesics, now vie with automobile accidents as the most common cause of accidental death.[1,2] Many observers identify these problems as recent phenomena originating in the 1990s.[3–5] This presumed novelty is key to the epidemic's most culturally compelling narrative: that drug abuse has escaped its traditional home among the non-White urban poor and has, via the medicine cabinet, run amok in respectable White suburbia, producing (as one typical news report put it) a "new breed of addict" in "the least likely corners of America."[6,7]

This narrative is wrong. Today's "epidemic" is just the most recent of three waves of mass abuse of psychoactive pharmaceuticals in America that stretch back over a century. Placing the current prescription drug "epidemic" in longer historical context is important because it provides a social laboratory of past approaches for dealing with the problem whose successes and failures have much to teach us. It also reminds us that even in an age when addiction is increasingly understood as a brain disease, many aspects of the problem that impinge on individual and community well-being are rooted in society, culture, and politics, and have changed over time.

The first wave of pharmaceutical drug abuse predated the category of "prescription drugs." By the late 19th century, the increased medical use of morphine (a substance known as "God's own medicine") and the newly discovered cocaine produced a sharp rise in drug dependence among White, middle-class men and especially women. It also eventually fostered popular markets in America's growing cities, where largely immigrant working classes adopted the use of opiates and cocaine along with amusement parks, saloons, brothels, and other aspects of a new and often disreputable popular culture.[8,9]

This wave of pharmaceutical drug use provoked America's first widespread antidrug campaigns. Initial efforts were voluntary: increased education of physicians and pharmacists through professional campaigns, and protective legislation (the Pure Food and Drug Act of 1906 [Pub L No. 59-384], which gave rise to the modern Food and Drug Administration [FDA], initially required only truth in labeling). But once established, drug markets were difficult to eradicate. Disturbed by the persistence of nonmedical heroin and cocaine use, especially in major cities, Progressive reformers passed the Harrison Narcotics Tax Act of 1914 (Pub L No. 63-223), which made opiates and cocaine America's first (and, at the time, only) prescription-only drugs.[10] A short-lived period of state and local experiments with opiate maintenance clinics was quickly quashed by federal narcotics authorities, who focused almost exclusively on supply-side measures to restrict manufacture and sale. Federal authorities and other drug "experts" accompanied those measures with demonization and punishment of drug users, whom they characterized as "junkies" with little hope of recovery.[11,12]

As preoccupation with fearsome "junkies" dominated drug policy, physicians and their "respectable" patients shifted to the use of newer, less stigmatized, and less tightly regulated drugs: barbiturates and amphetamines, which became the foci of a second wave of pharmaceutical drug abuse lasting from the 1920s to the 1970s. Although barbiturates had first been introduced in 1906, they were not widely used until after the Harrison Act, after which they became one of the most common

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prescription ingredients.[13] Amphetamines became medically available in the 1930s and quickly came into mass use as diet aides and antidepressants after use was normalized for millions of soldiers during World War II.[14]

It did not take long for abuse of both barbiturates and amphetamine to become a serious problem. Medical and media concern about abuse of these newer pharmaceuticals prompted new regulatory efforts. Again, the first attempts were voluntary: medical authorities (including the FDA) organized campaigns to educate physicians, pharmacists, and patients about the meaning and dangers of inappropriate use. The next step, at midcentury, was to restrict amphetamines and barbiturates to prescription-only status, much as the Harrison Act had done for opiates and cocaine. But the medical and pharmaceutical lobbies successfully petitioned Congress to make the new regulations much weaker than those inaugurated by the Harrison Act.[15] They were able to do so in part by playing on sympathy for the drugs' largely White and middle-class users, whom they contrasted with threatening "junkies." In the end, the new law did not criminalize nonmedical barbiturate or amphetamine use. It placed no restraints on manufacturers, physician prescribing, or possession by consumers, with predictable results: continued mass medical use, accompanied by growing illicit markets.

This situation changed only in the later 1960s, when increasingly visible nonmedical use of barbiturates, the rise of the disease model of addiction, and a new skepticism toward drug companies helped blur cultural distinctions between pharmaceuticals and their "respectable," more well-to-do users and "street" drugs and their stigmatized, urban, often minority, "junkie" users.[16] In this atmosphere, a diverse coalition of drug-law reformers, including the American Medical Association and the American Bar Association, successfully challenged the worst excesses of the punitive "drug war" while, at the same time, expanding regulation of pharmaceuticals. Their campaign culminated in the watershed Comprehensive Drug Abuse Prevention and Control Act of 1970 (Pub L No. 91–513), which brought all drugs with "abuse potential" under the Drug Enforcement Administration and its Schedule of Controlled Substances. The law's pharmaceutical regulations were directed principally at manufacturers, physicians, and pharmacists; end users were subject to new forms of policing and punishment, but were also offered a range of new treatments (including methadone maintenance) in keeping with the newly prevailing disease model. This system notched impressive victories. Medical use of barbiturates and amphetamines, which had been growing for over half a century, saw a sharp decline. This was not a shift to newer pharmaceuticals, as occurred after the Harrison Act, but a steep, across-the-board decline in pharmaceutical use and abuse.[17]

The reprieve was brief, however, and ended abruptly in the 1980s. A law-and-order turn in drug policy revived dormant "junkie" stereotypes and empowered a new round of punitive laws that targeted urban racial minorities, especially in the wake of sensationalized media attention to "crack" cocaine.[18] Meanwhile, pharmaceutical companies began to unveil a series of new sedatives (e.g., Xanax and Halcion), stimulants (e.g., Adderall), antidepressants (e.g., Prozac), and analgesics (e.g., the extended-release opioid OxyContin), which they claimed were less subject to abuse. New ideas about pain treatment justified widespread prescribing of opioids for the first time in a century.[19] Once again, the ingredients of an "epidemic" were in place, and today we are witnessing the results: a third wave of pharmaceutical drug misuse and dependence concentrated largely among White, working-class and middle-class Americans, many in rural or suburban areas. Nonmedical prescription drug use is now more prevalent than use of any illicit drug except marijuana.[20]

Responses to this wave are still taking shape but have followed a familiar pattern. The first measures were voluntary and focused on educating physicians and the public—for example, the overdose prevention and opioid safety program Project Lazarus in North Carolina, which aimed to raise awareness among community groups and clinicians of the risks associated with prescription opioids.[21] Then came supply-side measures such as prescription drug monitoring systems and heightened regulation through the Schedule of Controlled Substances. These were accompanied by law enforcement measures, including intensified policing; increased criminal penalties for the diversion, sale, and illicit possession of controlled prescription drugs; and heightened efforts to prosecute "rogue" doctors who prescribe what are deemed to be inappropriate amounts of opioid analgesics.[22]

Supply-side and criminal-justice approaches will likely be part of any US drug policy, but history offers little evidence that primary reliance on such strategies can genuinely reduce problematic drug use. Instead, these approaches have tended to shift problematic drug use to new substances while bringing negative consequences to those already dependent on drugs and their communities. We can already see this dynamic occurring today, as restrictions on prescription opioids have prompted many nonmedical users to turn to heroin as a cheaper and more readily available (but potentially riskier) alternative, thus establishing new heroin markets in previously "heroin-naïve" areas.[23,24]

This is why an expanded public health response—exemplified by strategies such as syringe exchange, medically assisted treatment (ideally delivered in a low-threshold, nonpunitive approach), and community-based overdose prevention and response training with naloxone distribution, all of which have been proven effective at limiting the health-related harms associated with drug use[25,26]—is more important today than ever. A central component of this public health response should be the development and widespread implementation of innovative prevention interventions to reduce the initiation and escalation of pharmaceutical misuse; these programs should be tailored for and delivered to both medical and nonmedical users of psychoactive pharmaceutical drugs.

This recent wave of pharmaceutical abuse presents us with a crucial opportunity to rethink our drug policy. For a century we have encouraged mass medical markets for certain drugs deemed to have therapeutic value while waging a "war" against close chemical analogs of those drugs. This system has ensured that the

next wave of drug abuse is always incubating even as warlike attempts to stamp out the existing one harm current drug users and their communities. To stop this cycle, we must stop making arbitrary distinctions between types of drug use, and make effective treatments and harm reduction techniques available to all drug users. AJPH

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