

Drug Addiction in America
Challenges and Opportunities
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I'd like to cover the subject material of drug addiction in America as the dew covers the ground. I am hopeful that you will use my remarks as a compass to find your way through this complex public health problem – one that cannot be solved by simplistic so-called solutions, embodied in catch phrases such as “Legalization” and “Medicalization” to the end that we find some solid guideposts.

Guideposts:

1. The keystone of the world of addiction is addiction to the legal substance, tobacco, because of its addictive ingredient, nicotine. Tobacco is a major risk factor in adolescents for getting drunk and using marijuana. The goal of the tobacco industry is to addict as many people as early as possible.

Everything else Big Tobacco does is “Theatre”. Because of the annual number of deaths world-wide, because of the economic implications of addiction, disease, disability and death world-wide, and because the primary target is children world-wide, the entire enterprise of Big Tobacco is the largest concentration of evil masquerading as a legitimate business on this planet.

2. There is no court of appeal because the lawmakers who could change the situation will not act because they are supported too heavily financially by the tobacco industry.

3. The stick to public health in an effort that is supported by appropriate measures to reduce supply. Understanding that the problem will not be controlled by overly focusing on the supply side.

I just used the word “appropriate”, one of two words essential to success. The other word is “flexible”; unfortunately, both words have been dropped from Washington's vocabularies.

4. It is easy to get addicting drug, but it is very hard, for most folks who need it, to get treatment.

I was told by a young man, one night in Denver, that he, in an unfamiliar city, could purchase cocaine within twenty minutes. He proved to be right. And I've learned the solution to drug addiction won't come until it is as easy to find treatment for drug addiction as it is to find addictive drugs.

5. Our national philosophy should be as finely tuned to getting treatment as the system is for interdicting drug runners.

6. Drug addiction is a disease, but whether you are concerned with tobacco, alcohol, or street drugs, it is more than just a brain disease; it involves social, economic, and psychological elements that must be addressed. In addiction, what may work for one culture may be inappropriate for another. (There's that word again." An example: Drug addiction is strongly influenced by social forces which can result in relatively low levels of tobacco consumption in states such as Utah, and California, but much higher levels in states such as Kentucky and Virginia.

Drug addiction can be strongly altered by factors such as cost and availability of the drug in question. We saw this when the drug cocaine went from being thought of as a relatively non-addicting drug in the 1970s, to becoming the flagship of addiction in the 1980s. It became cheap and available, and that epidemic emerged in the early 1980s even before the general availability of the "crack" form of cocaine.

This brings me to the physical form of some of the drugs in question. Cocaine got even worse from the public health perspective when it became more like cigarettes than a forbidden street drug, when it could be sold in relatively inexpensive doses in a form that could mimic the rush effects of an injection by the simple act of smoking the drug.

Wine coolers marketed next to soft drinks in supermarkets do not make alcohol more addictive. They make alcohol more acceptable and easy for adolescents to consume.

Marijuana is widely considered to be non-addicting by some people who do not realize that its potential is constrained only by the limitation on its availability. Would a person in favor of legalizing marijuana want his commercial airline pilot or his surgeon smoking marijuana?

Members of congressional committees, held the misconception that if one ever kicked the habit, we was not addicted. How could nicotine be addictive, they argued, when so many people stop smoking? Education on addiction can never stop.

7. We need compassion for those afflicted with addictions and help them with the same passion we reserve for other sick and injured.

There are also moral and criminal aspects that are prominent in the sale of illicit drugs. Or for that matter, in the deplorable marketing to children and adolescents by tobacco

companies to provide the pipeline of new smokers needed to replace those being killed by their products.

I'm talking about compassion for the addicted person; I'm not talking about compassion for the drug lord or the tobacco executive. Motivated only by greed and having already abrogated any sense of personal responsibility.

What is the difference between a drug lord in Columbia, his lieutenant in Miami, or an executive of a cigarette company? None! They are all evil; I would gladly spend the rest of my life bringing them to their knees, where I confess, I would deal with them without mercy. They are the real terrorists.

And then we have prescriptions drugs in which the control mechanisms are intended to provide the right balance to enable appropriate (there's that word again) patient access, while reducing diversion and abuse. If the right balance is not struck, patients in need may suffer while abuse still continues. There are ample examples of this where overzealous government agents bent upon eliminating all addictive drugs from the marketplace run roughshod over the fundamental basis of palliative care. Oddly enough folks taking morphine for its intended purpose – relief of severe pain – seldom become addicted.

What then is the right message concerning prescription drugs? Certainly not that analgesics, for example, are bad. The fact is that morphine and its analogues are not only among the most addictive of all drugs; but morphine is also the most effective drug for people with intractable pain. On the appropriate use of morphine, hang a number of ethical issues, such as assisted suicide, euthanasia and so on.

So an appropriate and flexible attitude toward the use of palliative drugs for pain is essential if we are to maintain the ethical structure for the practice of palliative medicine.

One of the most important sentences I think I ever wrote was when I rightly said in the report on acquired immunodeficiency syndrome that President Reagan asked me to write for the American people: "We are fighting a disease and not the people who have it." We are also not fighting the victims of addiction; we are fighting the disease that causes their problem. So, we need to:

8. Fight the disease of addiction and the purveyors of disease, not those afflicted. Too often blame is laid on those with addictions as though they sought and intended to become addicted. Perhaps they made poor choices about drug use, but all too frequently the choice was made during adolescence or before. That is not the same thing as having decided to abuse and become addicted to drugs.

In my own studies, I became totally convinced that most adolescents like congressmen understand very little about the nature of addiction. They're more likely to use the term

“habit forming” -- but they are totally confident that such would never happen to them, because they would never let it happen to them. Addiction doesn't come heralded by a band; it sneaks up, sometimes with extraordinary rapidity.

The problem becomes more complex when we consider the vast differences across drugs in terms of the nature of their addictive and damaging effects. For example, the case of alcohol, the damage and harm ranges from violence, false courage, poor judgment, and drunk-driving homicides to liver cirrhosis that may develop in heavy drinkers: yet the evidence is clear – that appropriate amounts of alcohol and in appropriate frequency can provide benefits in terms of reducing the risk of heart attacks.

But in the case of heroin some deaths are caused by overdosing the drug itself. But most of the tragedies with heroin are the results of side effects of the addiction – that lead to the contraction of HIV/AIDS, or hepatitis, through the use of shared paraphernalia for taking heroin intravenously – very much a part of the cult of “sharing” in I.V. drug abuse.

With cocaine, the lucrative and highly competitive trade itself has become a source of deadly violence certainly augmented by overly aggressive actions that are part of the body's physiologic response to high doses of cocaine.

Nicotine is addicting, but does not cause cancer, nor for that matter is it considered a major factor in most tobacco caused disease.

The recent reports of misinterpreted N.C.I. research on television and in the printed press concerning nicotine and lung cancer were not only incorrect, but a disservice to smokers trying to quit by using nicotine patches or gum.

One of the highlights of my tenure as Surgeon General was the release of the surgeon General's Report to congress on Addiction in 1988. Big Tobacco denied the science and truth of that report, but subsequent disclosures of hitherto secret documents revealed they knew much more about the addictive nature of nicotine than did the federal government, and knew it decades earlier. And can we ever forget the CEO's of the major tobacco companies lying individually under oath before a congressional committee in 1990, saying that they “didn't believe nicotine was addictive”.

Before a congressional committee, more than once, I was asked if nicotine is as addictive as I said it was, why aren't people shooting other people in order to get it? My answer was: “Remove nicotine from society, and you will see the same behavior that you see in reference to cocaine.”

Another frequently asked question was: “If tobacco is as dangerous as you say it is, why don't you take it off the market?” The answer: “With close to 50 million folks addicted to nicotine in this country, it would not only be inhumane, but unmanageable to remove the fix from so many people. That's why the FDA, an arm of the United States Public Health Service, would never suddenly abolish tobacco or remove nicotine from tobacco products.”

9. (The ninth and last guidepost): we need innovation in education, prevention, treatment, and policy. The vagaries of addiction, like a mutating virus, force us to alter our strategies with equal speed.

As I have grown older – I think I’m beyond calling that a process of maturation – I have come to realize that clichés I have used might be detrimental to my overall goals in public health.

A statement used by many people who are in the business of tobacco control is, “Smoking Kills”. If we just talk about death from tobacco, we leave out all the dreadful things that precede death such as sickness and disability. I rather have the feeling that if I were suffering from chronic obstructive lung disease, I would view death as a friend and not an enemy.

Also, I think I have been wrong in using “war” as a metaphor in discussing tobacco. We speak of the tobacco wars; we use words such as battlefield, enemy, fight against evil, etc. Now, I know that in a sense we are at war against the tobacco industry, against the drug lords, their distributors, and their pushers, but if we begin to think that this is the kind of a war that can be won like a national war, or that we can eradicate addiction as we eradicated smallpox, certainly we are doomed to failure even though our rhetoric sometimes seems to be accompanied by the sweet smell of success. I said earlier who I thought the real terrorists were. IF you are going to use a war-like metaphor, maybe one associated with terrorism, in which the enemy is constantly moving, changing his tactics, attacking from within and without and from unexpected places, which leaves us with no single target to get in our sights is a better metaphor.

We have to be careful with disease metaphors as well. We are certainly not dealing with smallpox, we’re dealing with something much more like HIV/AIDS, where the forces that cause the spread of the problem are many and diverse while the obstacles to appropriate action are more caused by indifference and prejudice than they are because of the disease process itself.

I was Surgeon General when the AIDS epidemic first became apparent. Public health actions were inhibited because we were dealing with a political disease of great complexity. Public health actions were precluded by the views of some that HIV/AIDS would run its course in homosexuals and in I.V. drug abusers, and after all, didn’t they deserve what they got?

I was the Surgeon General of all the people in America and one who cared about all the people and one who also understood that there was no such thing as a disease that would keep itself confined to one or two socially identifiable – and at the moment – despised populations.

Aids brought something new to American medicine, and it has strong implications for our concern about addiction. In the early stages of the AIDS epidemic, for the first time in American history we saw health professions withholding their expertise from people because they didn't like how they became ill.

Being as close to the epidemic of AIDS, as I was, and filling the role of spokesperson for the government to the public on AIDS, I am really proud of the work of the public health community and how much was accomplished in this area of medicine. I wish I could be as proud of our fight against addiction.

HIV/AIDS and nicotine addiction are similar in that with proper treatment and by dealing with them as the public health menace that they are, we can offer individuals the opportunity to live out their normal life expectancies.

We still have a long way to go, both in treatment and prevention. Above all, there is no such concept as a disease that is someone else's problem.

Addiction is a global tragedy. Tobacco poses the same global implication, as does HIV/AIDS. What has happened to the global conscience? How can we countenance the fact that 500 million people alive now on the planet will die prematurely in the next 25 years? If that's too big a number to take in, let's talk about my small state of New Hampshire. Thirty-four thousand children now alive in New Hampshire will die prematurely from tobacco. Where is the outrage?

For those of you who anchor their thoughts with numbers – here are a few:

About 25 per cent of the adult population or 50 million individuals smoked throughout the 1990s. Youth figures for the early 1990s were also high, but now have decreased for the past three years. Smoking is associated with binge drinking. Marijuana, and other illicit drugs. It is not the cause of other drug abuse, but it is a strong risk factor.

Tobacco is responsible for approximately 430,000 deaths each year, because of the time lag, this number will not be reduced even with major youth prevention efforts for two or three decades; nevertheless, increased cessation programs and treatment could reduce the number dramatically and within a few years.

The adult use of alcohol has been relatively stable over the past decade, but about 8 per cent of users have abuse or addiction problems. When we come to the problems of youth, 50 per cent of high school seniors drank in the last thirty days, 32 per cent binged and I'm using more than five drinks as a criterion. This is a very serious problem on every college campus, except those religiously oriented, where drinking is banned.

Alcohol is responsible for adult 100,000 death each year; half of these are due to drinking and driving, which peaked in the 1980s and has been declining since the age of alcohol procurement was increased to 21 and other measures such as, decreased blood alcohol

levels (BALS) came into force in the form of more strict criteria for driving under the influence.

With the false diminished perception of the risk of smoking marijuana, use became more prevalent during the 1990s and for that reason heavier use also increased in that same decade. As I said before, only limitation of availability curtails its use.

Cocaine had its great increase in the 1970s and 80s, because the supplies were plentiful and the drug was relatively inexpensive. When smokeable crack came on the scene in the mid-1980s, it compounded the problem by making cocaine much more like cigarettes – that is relatively cheap and convenient to use. Crack is made by reacting the hydrochloride salt-form of cocaine with baking soda, and essentially mimics the effects of a rapid I.V. injection.

From the jurisprudence point of view, criminal sentencing is much more severe for crack cocaine, even though such sentencing disparity is not supported by the pharmacology. Cocaine use seems to have peaked in the 1980s and has declined somewhat in the 1990s, probably because of the increase in perception of risks.

Heroin increased during the 1990s and street supplies are relatively inexpensive and much more potent than they used to be. Heroin and cocaine were involved in 70 per cent of illicit drug deaths. About 16,000 direct deaths occur per year from illicit drugs, but one has to remember that frequently that involves combinations of drugs and includes alcohol.

When doing a tally on deaths associated with drugs, accuracy demands the addition or perhaps 10,000 more additional deaths, which are due to diseases associated with drug use to diseases associated with drug use including: AIDS, Hepatitis, tuberculosis, and injuries to individuals who are out of control on drugs. Looking at it in another way, about 35 per cent of the AIDS deaths in this country are linked to drug abuse.

As has already been stated, HIV is transmitted by shared hypodermic syringes and other paraphernalia, which is most common in heroin users. HIV is also transmitted by sexual practices of drug users including prostitution to pay for drugs, which appears especially common among cocaine abusers.

The costs of substance abuse calculated as recently as 2001 is enormous. Alcohol is responsible for the expenditure of \$166.5 billion; 46 per cent in lost productivity due to illness, 21 per cent in lost productivity due to premature deaths, and 12 per cent in medical and health services.

Tobacco is responsible for \$138 billion; 58 per cent is used in medical and health care services, 36 per cent in lost productivity due to premature deaths, and 6 per cent in lost productivity due to illness.

Illicit drugs cost the nation about \$109.9 billion; 58 per cent related to drug related crime, 16 per cent in lost productivity due to illness, 15 per cent in lost productivity due to premature deaths.

Those last figures seem to indicate that illicit drug trafficking and competition among drug dealers is a major factor in violent crime in many cities. In state prisons, the proportion of drug offenders rose to 23 per cent from 1985 – 1995 and accounted for the tremendous number of 224,000 prisoners in 1995.

In federal prisons, the proportion of drug offenders is even more impressive than in state prisons where the numbers of proportion of drug offenders rose from 34 per cent to 60 per cent from 1985 – 1995 and accounted from 52,000 prisoners in 1995.

And now, I take the speaker's prerogative of shifting gears. Having told you that addiction in America is a terribly complex problems that cannot be dealt with simplistically, I'm not going to tell you that I have the answer in the form of a simple solution.

My suggestion is to treat drug addiction with the preconceived notion that it is a controllable public health problem and that the common sense use of appropriate and flexible proven public health – focused measures of control – are able to accommodate the diverse problems faced today. Perhaps we don't even understand the drug types and social behavior surrounding drug abuse that will be our headaches of tomorrow. What if we applied comprehensive public health approaches to the control of drug addiction?

What if we recognized that a person could develop an addiction to a drug even as he or she can develop diseases such as liver cirrhosis from alcoholism or lung cancer from cigarette smoking?

Suppose we relieved the Coast Guard of the task of chasing drug runners through the Caribbean and let them return to their chartered obligation of protecting our coasts?

What if we brought a better balance to supply and demand reduction efforts by increasing our ability to help those afflicted with addiction, so that they would not perpetuate the cycle in themselves and pass it on to others?

Suppose I could have told the young man in Denver who bragged about being able to find cocaine in twenty minutes, that I could find help for him by calling an 811 number?

If we really believe everything we know to be true about tobacco addiction and understand it as a serious preventable risk factor for other forms of drug and alcohol abuse, why have we never had a drug czar that understood the burden of the abuse of legal drugs like tobacco and alcohol instead of concentrating solely on illicit drugs?

What if the secretary of Health and Human Services wanted to make the treatment of addiction a comprehensive and a coordinated goal of the Public Health Service?

The National Institutes of Health could increase its funding of research efforts aimed at addiction, and the FDA could put any drugs resulting from such research on a fast track (as they did for drugs of possible benefit to HIV/AIDS).

What if the Public Health Service began to talk with the Drug Enforcement Administration?

What if the White House instructed the drug czar to stop chasing fast smuggler's boats in the Gulf of Mexico, but to make sure that emerging treatments were not so restricted that making them accessible to treating addiction would be a practical impossibility?

Recently the FDA approved Buprenorphine, a new treatment for heroin addiction. This treatment is as effective as methadone, and offers advantages for at least some people who are either receiving methadone or for whom methadone is unacceptable or unavailable.

More important, the road to its practical accessibility was first paved by congressional legislation and supported by the last president, and the Departments of Justice and Health and Human Services. So this drug will be made available through doctors' offices across the country; it is a minor inconvenience that such physicians will need special certification. The important thing is that the drug's use will finally make treatment available where drugs are as accessible as my young friend proved but where treatment is still an unattainable dream.

Let me give you an example of how public health can work and why public health does not mean only, "Either/or" when it comes to policy, supply reduction, or demand reduction. In 1988, during drunk driving month, just before the holidays, I was a credible Surgeon General, and I organized an invitational Surgeon General's Workshop on Drunk Driving.

The brewers of America joined with the vintners of America in going before federal court to get an injunction prohibiting me from having such a conference. How could anyone be against drunk driving? They lost, and we had the workshop. But the workshop participants were mad enough to get the job done.

Some of you were too young to remember that this was a time when the states were being required to raise the minimum purchase age for alcohol beverages to 21, were being strongly encouraged to reduce the blood alcohol level (BAL) used to define "driving while intoxicated" (DWI) and to take measures to more effectively educate the public about the dangers of drinking and driving, and to encourage more aggressive efforts to get drunk-drivers off the highways.

The supporting coalition was broad and included many scientists. Voluntary organizations such as Mother's Against Drunk Driving, the Department of Transportation, Law Enforcement Organizations, and the administration, the participants in this workshop went home and pursued aggressively the recommendations of the group. Taken together the results of these actions are most impressive.

During the 1970s, when state after state lowered its minimum age of procurement of alcohol to 18 or 19, highway deaths among young people soared. Then as these age levels were increased in the context of many other public health efforts that I have just mentioned, and more, the death count began to decline state after state – in essence, a grim experiment in national drug control policy, but one we should learn from and take to heart.

Let me give you another example. During the 1980s, cigarette smoking among adult Americans seemed to have become stuck at about 25 per cent of the population. By the early 1990s; smoking among youth began to increase dramatically as cigarettes became more effectively promoted and their relative price dropped so low as to make this an addiction even young people could afford.

In the past three years, with increased cigarette prices caused by increased taxes and tobacco litigation payments with increased anti-tobacco campaigns from groups such as the American Legacy Foundation, with the tobacco control efforts of states like Massachusetts and California, with increased restrictions on workplace and public smoking, and with the increased availability of treatment as well as advertising to stimulate cessation, smoking in all populations has decreased with the greatest declines among the young.

However, it is a never ending battle with the budgetary crunch in almost every state in the union, tobacco monies to the states from the settlement are being used, not for their intended purpose – the prevention of youngsters starting to smoke or the treatment of addicted smokers – to balance the budget, and fill potholes.

The result is further diminution of tobacco funds, already being used for the wrong purposes, with unwanted sequelae for the states.

In Massachusetts, for example, Governor Swift cut the program funding from \$48 million to \$4.8 million and then the new Governor Romney diverted whatever money was remaining, potentially eliminating the best anti-tobacco program in the country.

In Massachusetts, over \$700 million is generated in tobacco excise taxes and the legal settlement money. Not a penny of that is being used for its intended purpose, and only 5 per cent of that money would fund a comprehensive tobacco control program at the minimum level recommended by the Centers for Disease Control and Prevention.

The Massachusetts Tobacco Control Program has lost 24 of 33 staff positions; the remaining 9 are funded with federal dollars.

The list of terminations and reductions unfortunately fills a whole page, single-spaced.

To bring the matter closer to home in New Hampshire:

The state gets \$43 million from the tobacco settlement. From here on, if the Governor and the legislature have their way, zero will go to prevention.

The budget also takes all the money from the Governor's Commission on substance abuse prevention and treatment fund, created in part by half of the increase in liquor revenues, now at \$4 million per year and give it away for other purposes.

Locally, the "Teens Make a Difference Group" serving Mascoma, Lebanon, Hartford, Windsor, Woodstock, and South Royalton is in jeopardy.

Please remember that progress is not the total elimination of addiction, it is the reduction thereof.

Here is another example that did not take place on my watch. Some of you may not know that Richard Nixon was involved in more than one war. As he put it, and the lesser-known war was on drugs. The Nixon Administration performed an experiment that we can learn from today.

When the administration realized that among returning Vietnam Veterans, there were potentially tens of thousands of heroin addicted soldiers who might soon be flooding the streets and spreading the crime and devastation assumed to be intrinsic to addiction – something had to be done.

The Army began the experiment with perhaps the most radical proposal of all. Without legalizing the drugs, it determined that soldiers identified as drug users would not face legal sanctions, but would be treated. Then it set a simple goal across the nation to make every effort to ensure that wherever there was addiction, there would be treatment access for all.

Within three years of their return to the United States, 90 per cent of the former heroin-using soldiers were clean, and cities, which achieved the most dramatic increases in treatment access, were rewarded with dramatic decreases of violent and drug associated crime.

It just shows that drug addiction can be modified by a variety of factors and we need to do a better job controlling those.

The mayor of Baltimore, Martin O'Malley was asked what people could do to protect themselves from terrorism.

He answered: “To protect yourselves from harm, the most important things you can do are to wear your seatbelts, don’t drink and drive, and don’t smoke.” I don’t think anyone thought he was trivializing terrorist threats, but it was an important reminder to keep things in perspective.

Perhaps he had in mind the apparent absurdity of the cigarette smoker purchasing an expensive gas mask to save his life; the chance of one in several millions, while he faces a one in two chance of devastating illness from that cigarette that will prematurely end his life.

Many youth on the road to chronic abuse and addiction may be helped if reached earlier by their own communities, their churches, their schools, and their families. It is clear that youth often respond more strongly to what their parents do, than to what their parents say.

But, that doesn’t keep from saying something to parents. “If you want to make a difference in contributing to the reduction to drug addiction and abuse in America, start by setting a good example. Don’t use tobacco or drink to excess. And I hope that it is obvious that you should not be abusing marijuana, or other illicit drugs, or prescription drugs yourself.”

The children of non-smoking parents are about half as likely to smoke, compared to the children of smoking parents. Also, non-smoking children are many times less likely to get drunk, or to smoke marijuana, or to use other addictive drugs. These are facts. More recent data show that when smoking parents of smoking children quit, their children in turn, are twice as likely to quit themselves.

Will non-smoking or reduced smoking by adults eliminate addiction in America? Of course not! But non-smoking and quitting smoking by adults will contribute to the reduction of addiction in America. Simply stated, if you care about illicit drug use and drunkenness, then you should care about tobacco use, because it is a high risk factor.

Eventually someone will ask if tobacco is a gateway to other addictions? What the facts show are that use of smokeless tobacco or cigarettes by adolescents is a major risk factor for getting drunk and using marijuana. That obviously means, it is a preventable risk factor.

That is why I believe that efforts to reduce smoking should not be seen as isolated efforts to reduce tobacco-caused cancer and heart disease. But rather it should be seen as part of our nation’s overall efforts to reduce addiction and to improve health in general.

If tobacco is a major risk factor for adolescents using marijuana, what’s the risk of marijuana?

At the end of January in JAMA (Vol. 289, #4, 1/22-29/03 in a paper dealing with the “Escalation of drug use in early – onset cannabis users vs. co-twin controls”, it was

concluded that the association between early cannabis use and later drug use and abuse/dependence may arise from the effects of peer and social context within which the cannabis is used and obtained. In particular, early access to the use of cannabis may reduce perceived barriers against the use of other illegal drugs and provide access to these drugs.

When I spoke before the American Lung Association and the American Thoracic Society in Miami in 1984, and gave a speech that I had deliberately neglected to pass before the watchful eye of OMB and the White House, I proposed that it was not impossible to look forward to a smoke-free society in America by the Y 2000. I was particularly interested in graduating a smoke free class from high school in the year 2000. I remember standing at that lectern and asking – almost demanding – that certain organizations put their shoulder to the wheel and help me in this effort.

I called specifically on organizations, such as the American Lung Association, the American Heart Association, the American Cancer Society. I called up the Boy Scouts and Girl Scouts, the Campfire Girls, respiratory therapists, pediatricians, obstetricians, and gynecologists. There was almost no one that I didn't think had a role in leading us into a position where we might see major progress in getting rid of the scourge of tobacco.

So, what can individuals and organizations do if they truly wish to be part of this public health approach to the reduction of addiction?

There are scores of things individuals can do. For starters; help abused and frequently drug abusing adolescents with compassion for the afflicted and a willingness to listen.

I'm sure you already know of missed opportunities where you live.

What can health professionals do? Many presenting patients are at substantial risk of having an addiction as a complicating factor; children with asthma who often are exposed to smoke in their households, persons with anxiety and depression who are more likely to smoke cigarettes and abuse alcohol than other patients, and people with fractures where healing might be slowed down by smoking.

Professionals are going to be the best that they can be in their specialty only when they know enough about addiction to identify it and refer their patients for more specialized help as indicated.

We need to build better bridges between Centers of Education and research and their communities, such as DCARE here at Dartmouth College, which is a campus – and – community – focused center for treating and preventing drug abuse and addiction.

The meeting on May 8th – community wide – at the Hanover High School is part of Robert Wood Johnson’s addressing the problem.

Next week on the 6th in the Hanover High School auditorium or gym we look forward to a meeting of folks from ten upper valley towns. At this meeting, young winners of leadership awards from Robert Wood Johnson will interact with the audience to see how we can all work to better serve the community in reference to these problems.

I got to the point in preparing this lecture when I realized that natural time constraints indicated that I had probably said enough. And yet, there was so much more to be said. As I draw this time to a close, let me just leave some concepts with you to ponder in the days ahead.

Addiction will always be with us; multitudinous factors are responsible for the rise to supremacy of one addiction over another from time to time. Let me pull a few loose ends together.

Public health should be a driving force in all of our coordinated efforts and that means maintaining a focus on public health improvement not morality, on increased education, increased treatment access, and although goal orientation might be the eradication of disease take pride in short and mid-term approaches to controlling the prevalence of disease and its consequences.

Remember that addiction is our antagonist not addicted people. Remember with pity the addicted individual in his misery and despair. Never think of him or her as either incurable or depraved. Don’t be fooled by the early arrogance of the addicted person; he or she still thinks control has not been lost; apparent arrogance is really to compensate for new perceptions of reality.

I try to remember not to call people with addictions – drug addicts. I propose that you do the same. The word addict carries a very negative connotation and suggests that the person is the problem rather than the disease. Compliance with treatment suggestions is much more likely, if the patient can see in us a healer of disease with no implication that some character flaw might indicate that they do not deserve treatment.

Having said those things, remember at the same time that the public health approach to the control of addiction and abuse does not mean that you are taking a permissive stance on drugs. Remember the attitude of the press toward cocaine in the late 1970s and in the 80s; how many more problems will we see with marijuana if we allow that same permissive attitude associated previously with cocaine to drift into our experience with marijuana.

Government policies can make a difference, but our future probably lies better in state action than waiting for federal response. One only has to look at what has happened to smoking in Massachusetts and California in comparison to their surrounding states.

What accounts for the difference? I suspect comprehensive efforts to reduce access to substances for abuse, more direct answers on the dangers of tobacco and the increased availability of treatment options.

Remember that public health is a lot more than calling to attention of how bad things are. Public health without a treatment component is not public health at all. Yet, at the same time, we have to remember that contrary to therapeutic and rehabilitative medicine, offering treatment without addressing prevention is a sham and a delusion.

None of these things I have mentioned as concepts, are the, be all or end all, in and of themselves. They must go hand in hand with all the concepts, and this is best done with public and private partnerships.

And now for a few personal reminders:

If you have a role in helping addicted persons, be sure that your behavior is appropriate and flexible enough to convince them that their best interests come first and that failure to comply with treatment, compliance and the misunderstanding of coordinated and comprehensive treatment plans will not result in punitive action.

Do all that you can to thwart the efforts of those who aid and abet addiction; never let them believe that they are a legitimate occupation. Don't be afraid to call a spade a spade. You can help turn tolerance by the public of the tobacco industry, for example, into distain. The public can be helped to turn its distain for those addicted into distain toward the perpetrators.

Don't funnel your energies about the prevention and treatment of the use of drugs into a stand-alone educational effort. Coping skills against the use of drugs are just as important in the basic education of school children as are instructions about diet, exercise, and sleep. Never forget that drug addiction is rather unique among diseases, because part of the disease process itself is to resist treatment or to deny its necessity.

Don't be upset by the irrationality of the arguments of the addicted.

Don't assume that your obligations to young people lie in prevention messages. Many of those you think are primed for prevention are already ensnared and ready for treatment.

Don't give the wrong medicine. On the other hand, remember that the prevention message can never stop. When you think you have educated a group of unknowing youngsters to the best of your ability about the need for prevention, remember that their numbers are already being replaced by another cohort that needs exactly the same message.

While health professionals are fighting hard for third party coverage for the treatment of addiction, those third payers may not understand that unlike their usual problem of over-utilization, under-utilization of addiction therapy is to be expected.

Drug courts need the understanding of appropriateness and flexibility so that they can help focus on treatment needs to supplement or even replace incarceration. Going to jail can turn a user into a user and a dealer.

It might seem trite to remind this audience that the world is shrinking, due to improvements in transportation and communication and that our problem is a global one. That means no matter where we work, we are dealing with multiple cultures, and one size does not fit all when it comes to therapy options. Globally speaking, we stand on the threshold of two enormous catastrophes: first, the spread of HIV/AIDS through the use of I.V. Drugs and second, the combined efforts of Big Tobacco to make cigarettes available to customers, especially women and children in every nook and cranny of this planet.

Their early success continues and if nothing happens, by global cooperation, to stopping tobacco in its tracks, it will be responsible for the premature death of 500 million people now living on this planet in good health.

Let me come back close to where I started and repeat that addiction is a disease; it is a brain disease. That's not just my idea; this is recognized by all leading medical and health authorities. The drugs physically impact the brain. They alter its structure and function. Scientists can even measure brain function, using electroencephalographic and brain imaging techniques, can actually see areas of the brain responding to drug administration and withdrawal.

Cigarette withdrawal can include a dysfunction of the brain so important that the ability to concentrate by many abstinent smokers is a real physiological effect. It can be treated with medications such as nicotine gum and patches. Similarly, heroin addiction can be treated with methadone, buprenorphine and other means.

But don't many people quit without treatment, you ask? Of course! Just as many people recover from streptococcal infections without antibiotics, but I hope you also know that many people have died needlessly from such infections because they did not receive treatment.

You might then ask, "Doesn't calling addiction a disease get people off the hook and take away their responsibility?"

The answer is no, nevertheless, we need to find the right delicate balance of holding people responsible for their behavior and working to identify and address the driving forces. This is not unique to drug addiction. Giving a patient a pharmaceutical should not imply that the patient has no further role in his or her recover.

It would be considered irresponsible to withhold medication from the diabetic or a hypertensive person if they were not adhering to their dietary plan, yet, in some addiction treatment settings, treatment may be withheld if the patient does not meet the standards for compliance set by that clinic.

Far be it from me to say that there should be no effort to use treatment to inspire compliance with all aspects of treatment, but I am saying that the first goal should be to help the person to achieve and sustain abstinence and that treatment should not only be a cornerstone of that effort, but an attitude which is appropriate and flexible.

I raised a question a moment ago, if calling addiction a disease might not lead to the abrogation of that individual's personal responsibility. I am at the very beginnings of what I think will be my last undertaking in this life. (No pun intended.)

I am putting together a huge archive with the national library of medicine, the interactive media labs at Dartmouth Medical School and the Baker Library at Dartmouth of my personal interface with the world of public health. It will be available on the Internet without cost, but it is an awesome task. Just my lectures alone fill 199 3-ring binders, many 4-inches thick.

In these volumes, I came across a bit of nostalgia when I found a lecture that I gave repeatedly in 1982, on the occasions when President Reagan asked me to come over to the old executive office building and talk to one group or another on some of his pet stands and legislative plans. It really wasn't a lecture; it was a series of talking points. I probably never gave them all at any one sitting, but I used many of them many times. The lecture has no name, but those who helped me with my speeches gave it a title, which was "A really Terrific Sermon". To talk of personal responsibility leads me to leave you with an idea – it is "A Really Terrific Sermon."

I think that a tremendous number of the ills of our society are caused by the abrogation of personal responsibility and/or greed. I would like you to take away from this session the thought that the addiction of the individual to a drug is not ever that individual's choice. Because of the addictive nature of the drugs in question it really can't be solely attributed to the abrogation of personal responsibility.

However, on the other hand, of all the individuals and organizations I have mentioned today in passing, which exhibit the abrogation of personal responsibility to the highest degree? It is the drug lords and their chains of command right down to the pusher. It is the decision-makers in the world of Big Tobacco and this abrogation of personal responsibility is made all the more onerous because it is fueled only by greed.

But whatever we think about the leeches who suck the life out of our young people, we must not let our zeal to reduce the supply of drugs lure us into forgetting those who have become addicted and who create a demand for addictive drugs. We must expand greatly our efforts to help those with addictions so that getting treatment will be as easy as getting addictive drugs. When the demand is reduced, so will be the supply.

Thank you.

