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Substance Use and Abuse: Exploring Alcohol and Drug Issues

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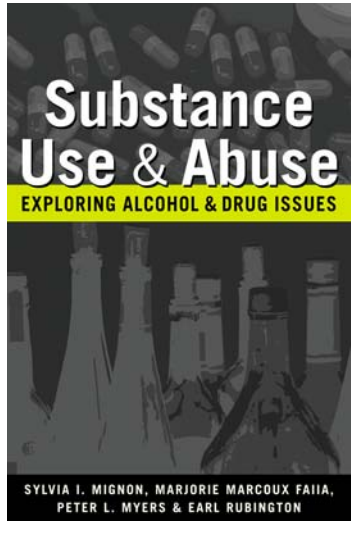

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1 Introduction: Substances and Society

It seems that every day another news report details how some-one famous has struggled with substance use and abuse. In 2007 and 2008, seemingly every supermarket tabloid and magazine featured weekly headlines about the substance abuse depredations of Britney Spears and Lindsay Lohan. Drew Barrymore was in rehabilitation—rehab—twice by the time she was thirteen, and in 1996 she admitted she had a coke (cocaine) problem. Robin Williams admitted to keeping a bottle of vodka in his fridge that he drank from throughout the day. The death of Anna Nicole Smith in 2007 was ruled an accidental overdose from prescription medications; this is eerily similar to the death of her idol, Marilyn Monroe. Smith's son Daniel had died only months earlier from a heart attack brought on by prescription antidepressant medications and methadone. In 2008 actor Heath Ledger died of an overdose of six different prescription medications.

Some celebrities have behaved in such bizarre ways while under the influence that the drama surrounding their substance abuse is compelling. Mel Gibson was stopped for drunk driving and shouted anti-Semitic slurs at the arresting officer. Britney Spears shaved her head, lost custody of her children, and entered rehab several times. Spears's highly publicized substance abuse drew the attention of pop psychologist Dr. Phil (McGraw), who attempted an intervention that initially he planned to air on television. A 2008 television show, *Celebrity Rehab with Dr. Drew,* showcased the trysts, trials, and tribulations of celebrities.

Well-known religious and political figures have also been in the news offering apologies for bad behavior related to substance abuse. The Reverend Ted Haggard entered rehab after accusations that he snorted meth

(methamphetamine) and had sex with a male prostitute. Mark Foley, a Florida congressman, resigned and entered rehab for alcoholism after sending sexually explicit e-mails to congressional pages. Patrick Kennedy, a Rhode Island congressman, entered rehab after he drove his car into a cement wall and claimed to have no memory of the incident.

Of course, it is not only celebrities and notables who struggle with the use and abuse of alcohol and drugs. Estimates from national data from 2007 found almost 20 million Americans (8 percent of the population) used illicit drugs within the past month (Substance Abuse and Mental Health Services Administration [hereafter, SAMHSA], 2008). Heavy use of alcohol was reported by 17 million (6.9 percent). Current national estimates are that 22.3 million people (9 percent) in the United States have substance abuse or substance dependence problems (SAMHSA, 2008). However, only approximately 10 percent of those in need of specialized substance abuse treatment receive it.

Substance use and abuse create significant societal problems with enormous personal, family, social, and health costs. On an individual level, substance abuse can create ravaged lives for the addicted and a rippling of negative consequences for family members, some of which can be lifelong. At a societal level, substance abuse is strongly associated with medical problems, crime, poor work performance, and absenteeism. The major institutions of health care, business and industry, and criminal justice bear much of the burden of responding to those with substance abuse problems. In reality, the costs of substance abuse permeate every facet of American society.

In turn, social context plays a significant role in how we understand drug use and drug policy. Social institutions such as religion, medicine, law, and education each have the authority to define appropriate and inappropriate use of alcohol and drugs. The role of cultural perceptions and classification are seen in the fact that tobacco products, delivering the highly addictive substance nicotine, were overlooked for their abuse potential until the 1980s. Although Surgeon General Luther Terry warned of the health hazards of smoking in 1964, it was not until 1997 that the Liggett Group became the first tobacco company to acknowledge smoking is hazardous to health.

Similarly, alcohol—the most used and abused drug in the United States—is not defined as a drug, but rather is perceived as a social beverage. Though it is not listed as a controlled substance, it clearly has considerable abuse potential, and some drinkers become physically dependent on it. Alcohol is the drug most implicated in personal, social, and economic damage. Examples of personal damage include deaths from cirrhosis of the

liver and other alcohol-related illnesses, from impaired operation of automobiles and boats, from aggravated assaults, rapes, homicide, and suicide. Social costs include domestic violence and divorce. Economic damages include lost hours at work, industrial accidents, poor work performance, health costs, and expenses incurred by the entire system of criminal justice.

Additionally, the social and cultural standing of substances drives law enforcement efforts. As we shall see, the major growth in the criminal justice system over the past three decades can be attributed to societal concern—described by some commentators as "moral panic"—about substance abuse. In the 1980s and 1990s, public opinion polls regularly recorded that Americans considered drugs to be the most severe social problem, and supported legal sanctions. On the other hand, champions of drug decriminalization claim that drug laws are an unwarranted effort to police decisions by individuals to alter their own consciousness.

Social forces may also factor into the prosecution of substance use and abuse. Alcohol use is one of many instances of the selective enforcement of substance control laws. While the proportion of alcoholics may be distributed throughout the social classes, alcoholics from the lower classes are more socially visible and therefore more likely to come to the attention of the police. This generalization about visibility holds for all varieties of substance use. It is further known that alcohol is more readily available in poor, black neighborhoods (Jones-Webb et al., 2008).

Drugs and alcohol permeate the social fabric of the United States. However, before we can truly investigate their role in society today, we must set the stage with a brief history of the use and abuse of major drugs such as narcotics, marijuana, hallucinogens, and cocaine as well as societal responses, including drug control policies.

Development of Narcotic Use

During the eighteenth century, some Americans used laudanum, a mixture of alcohol and opium, while others consumed opium in solid or liquid form. While not illegal, opiate use and addiction grew in the nineteenth century. Use typically took place in homes, making it hard to estimate the number of users. The fledgling medical profession adopted morphine, soon after it was derived from opium in 1809. Physicians soon came to see morphine as a cure-all and prescribed it for almost every ailment (Terry and Pellens, 1928). The arrival of the hypodermic needle in 1849 increased the use of morphine by physicians and laypeople alike. The last half of the nineteenth century became "a dope fiend's paradise" (Brecher et al., 1972).

Grocery stores and pharmacies sold patent medicines, all containing a variety of opiates, and Sears Roebuck sold opiates through mail order. Physicians prescribed morphine, sometimes giving their patients hypodermics; pharmacists dispensed narcotics without prescriptions. Half the addict population was medically addicted through overmedication by physicians, with more addicted women than men. The typical addict was white, rural, female, lower-middle-class and middle-aged, although the poor and minority populations were also afflicted.

In 1875 a number of western states, fearful of the effect of Chinese opium dens on their youth, outlawed either attendance at opium-smoking dens or smoking opium. By the mid-1880s a dozen states had passed a variety of antinarcotics legislation, much of it fueled by anti-immigrant prejudice (Musto, 1987). Many influential groups became concerned about the increase in the number of addicts, the importation of opium and other drugs, and the manufacture and sale of over-the-counter products that contained opiates. They helped to achieve passage of the Pure Food and Drug Act of 1906, which required labeling contents of all over-the-counter products containing opiates. Reformers recognized the states' inability to enforce their drug laws and pressed for a federal response. National drug control finally became law with the passage of the Harrison Narcotic Control Act of 1914.

Passage of the 1914 act, originally designed as a tax act, marked the first step in the evolution of our punitive national drug control policy (White, 1998). Treasury enforcement agents interpreted physicians' numerous refills of prescriptions as illegal, rather than as appropriate treatment. Their interpretation of the act drove physicians out of practice, criminalized drug addicts, and fostered a black market supplying drugs at inflated prices (Musto, 1987).

The Harrison Act foretold the victory of the "hard on drugs" constituency over the "soft on drugs" approach. Punishment prevailed over treatment, and law prevailed over medicine. Treasury agents interpreted gradual withdrawal or maintenance doses by physicians as illegal narcotic sales rather than legitimate medical treatment (Lindesmith, 1965). Some 25,000 physicians were arrested and 3,000 jailed. With drug addiction considered a crime rather than a disease, addicts, deprived of legitimate access, sought another source of supply. A black market developed to fulfill the demand at inflated prices. The drug of choice had become heroin.

In 1901 the German firm Bayer began marketing heroin legally after its derivation from morphine in 1898. It soon became the new wonder drug, a cure-all especially for morphinism and alcoholism. Early on, however, officials soon recognized the addictive power of heroin—ten times

the strength of morphine—and it became outlawed. The setting of use and the characteristics of the heroin-using population changed after the Harrison Act. Low-income youths, white, black, and Hispanic, in inner-city neighborhoods became the most visible users. "Crime in the streets" became a politician's mantra, with harsh mandated prison terms standard policy. The Boggs Act of 1950 mandated the death penalty for those selling narcotics to anybody under the age of eighteen.

The peak of heroin use occurred in the late 1960s, with a reported 750,000 heroin addicts in the United States. As of this writing, approximately 3.7 million Americans 12 and older have tried heroin at least once in their lifetimes. In 2007, people who had tried heroin for the first time within a one-year period numbered 106,000, an increase over the 91,000 people who first tried heroin in 2006 (SAMHSA, 2007a, 2008). The average age of first use was 20.7 in 2006 and 21.8 in 2007. Approximately 227,000 heroin users were diagnosed with heroin abuse or dependence in 2004, 323,000 in 2006, and 335,000 in 2007 (SAMHSA, 2005b, 2007a, 2008).

Development of Marijuana Use

Planters grew the marijuana plant hemp during the early years in America, and physicians found some medical uses for marijuana. The drug became notorious when newspapers reported crime waves in New Orleans in 1926. According to police, the rise in crime was attributable to smoking marijuana, a habit acquired from Mexican immigrants. Police, much like many physicians, thought marijuana gave smokers the courage to commit criminal acts. They mistakenly attributed the characteristics of cocaine, a stimulant, to marijuana, a drug more likely to induce passivity and detachment rather than aggressive action. Louisiana made possession or sale of marijuana punishable by six months in jail or a $500 fine. In 1929, Colorado passed similar laws after an influx of Mexican laborers migrated to work in the sugar-beet fields (Brecher et al., 1972).

Anxiety and concern about the use of marijuana spread mainly through the efforts of Harry Anslinger. Though a Prohibition enforcement agent, Anslinger had actually argued that reports of widespread use of marijuana had been exaggerated by the press. However, as the new head of the Federal Bureau of Narcotics, he waged a powerful campaign in all the media against marijuana, the "killer weed" (Becker, 1963; Bonnie and Whitebread, 1974). The documentary *Reefer Madness* illustrated the life of debauchery and crime for which marijuana users were destined (Faupel,

Horowitz, and Weaver, 2004). Anslinger lobbied Congress to endorse a punitive policy to curtail the marijuana menace. Impressed by Anslinger's argument, Congress passed the Marijuana Tax Act of 1937, which placed a tax on marijuana of $100 per ounce. The act effectively outlawed marijuana. Anslinger's antidrug policy consisted of mandatory harsh penalties with increasing severity for repeaters. By 1937, forty-six states passed laws whose penalties equaled the severity of those imposed for cocaine, heroin, and morphine violations.

Meanwhile, marijuana had begun its cultural climb through the American social structure. Sailors, prostitutes, and criminals took to smoking marijuana. Jazz musicians also adopted marijuana use and, when they later moved to Chicago and New York, contributed to its spread. In time, the "beat generation" of the 1950s took up marijuana smoking, to be followed by the hippies of the 1960s (Polsky, 1969). It soon spread to the college students of that generation and antimarijuana hysteria gripped middle-class America.

Before Anslinger's campaign there had been low use of marijuana and high social tolerance. After Anslinger left office, tolerance lessened while use increased. Arrests mounted, legal penalties grew harsher, and antimarijuana propaganda stoked growing fears that smoking "reefer" would only be followed by "madness," rape, and murder. California's arrests for possession or sale of marijuana swelled to 50,127 by 1968. President Richard Nixon's commission's special report on marijuana law enforcement revealed that college students had replaced low-status smokers as the prime violators (Shafer Commission Report, 1972). However, some middle-class judicial personnel were unwilling to find students guilty and sentence them to jail. Children of governors, senators, and others in the public eye rarely received even short prison terms (Brecher et al., 1972).

While the high arrest–low conviction ratio frustrated blue-collar police, the white-collar elite triggered a movement for decriminalization. A dozen states lowered the penalties, with a few reducing possession of a small amount of marijuana to the status of a traffic offense. And as personal knowledge as well as accurate information about marijuana's characteristic effects spread, its mythic description as both a stimulant and a narcotic lost credibility.

As we have seen, attitudes toward drugs such as marijuana vary with the generations and the times. A total of 96.8 million people have tried marijuana at least once in their lifetimes as of this writing. Some 25.5 million used it at least once in 2004, and this number dropped to 2.1 million in 2006, remaining the same in 2007 (SAMHSA, 2007a, 2008). In self-reports of marijuana users, 4.2 million acknowledged marijuana abuse or

dependence in 2006 with a slight reduction to 3.9 million users in 2007 (SAMHSA, 2007a, 2008). Unlike most users of illicit drugs, only 40 percent of users had to buy marijuana and more than half got the drug for free or shared someone else's marijuana. Some states have decriminalized marijuana, although in 2006 there were over 700,000 marijuana arrests, most of them for possession.

While those who support decriminalization often say it is less harmful than alcohol, marijuana use is not without some long-term effects. These can include loss of motivation, known as amotivational syndrome (see Box 1.1), and a lower sperm count for men (Drug Enforcement Administration [hereafter, DEA], 2005; Grinspoon and Bakalar, 1997).

Development of Hallucinogen Use

In 1943 Albert Hofmann, a chemist at Sandoz Laboratories in Basel, Switzerland, took the first recorded LSD (lysergic acid diethylamide-25) "trip." Hofmann had discovered LSD when studying the medicinal use of

Box 1.1 Kurt Smokes Marijuana

Kurt, a man in his midtwenties, contacted the Employee Assistance Program offered through the popular restaurant he worked for in New Bedford, Massachusetts. Meeting with a social worker in a private office, he explained that he needed some help in moving forward with his life. He had dropped out of college several years before and was working as a waiter. While the money wasn't bad, Kurt told the social worker that he felt he was not living up to his potential and that he seemed to lack motivation. He discussed his family background and his early success in school. In asking Kurt about his use of substances, the social worker learned that Kurt consumed heavy amounts of marijuana on a daily basis and had done so for several years. The social worker suggested there might be some relationship between his heavy pot-smoking and feeling he was not able to accomplish much in his life. Kurt responded that he had never considered his daily marijuana smoking could be a problem. Kurt agreed to another appointment with the social worker, but failed to show up. The social worker called Kurt and wrote him a letter, trying to engage him in therapy, but received no response. The social worker later reflected that Kurt did not want to stop smoking marijuana or examine the relationship between marijuana use and his behavior. Could Kurt be an example of amotivational behavior?

fungus on grains, including wheat. He described his first trip as "wonderful visions. What I was thinking appeared in colors and pictures" (Associated Press, 2008, 21).

Hofmann hoped LSD would be used to treat mental illness. By 1965 some 30,000 to 40,000 patients had been treated with LSD in the United States and Europe, reportedly with no adverse effects (Brecher et al., 1972). When Hofmann died at the age of 102 in 2008, his obituary recounted his view: "I produced the substance as a medicine. It's not my fault if people abused it" (Associated Press, 2008, 21).

Timothy Leary, a Harvard University faculty member, is perhaps the best-known academic to research the effects of LSD and other hallucinogens. See Box 1.2 for a description of Leary's activities.

Box 1.2 Timothy Leary (1920–1996)

Timothy Leary became famous for coining the popular catchphrase of the 1960s: "Turn on, tune in, drop out." A psychologist and writer, Leary was also a campaigner for the use of psychedelic drugs.

Leary was born in Springfield, Massachusetts, and attended the College of the Holy Cross in Worcester, Massachusetts, and also West Point. He dropped out of both but went on to earn a bachelor's degree in psychology from the University of Alabama in 1943. In 1950 he earned a Ph.D. in psychology from the University of California at Berkeley. Leary spent years as an assistant professor at Berkeley and as a director of research for the Kaiser Foundation in Oakland, California, before becoming a lecturer in psychology at Harvard University, where he remained during 1959–1963.

On vacation in Mexico in 1960, Leary used psilocybin mushrooms for the first time. This captured his interest and led him to conduct research into the hallucinogenic properties of psilocybin and, later, the effects of LSD on graduate students. Leary and his colleague Dr. Richard Alpert, who later became known as Ram Dass, believed that with the appropriate guidance and supervision, LSD could benefit users by giving them mystical and spiritual experiences that had the potential to be life transforming in positive ways. Volunteers for his experiments included graduate students and the author Jack Kerouac. Leary hoped this work would improve treatments for alcoholism and help prison inmates become rehabilitated. However, parents of Harvard students complained, and other colleagues found the work of Leary and Alpert more than disquieting. Both were fired by Harvard. They continued their work at a mansion known as Millbrook in New York and were raided later by the Federal Bureau of Investigation (FBI).

continues

Box 1.2 (continued)

In 1965 Leary's daughter was caught with marijuana while traveling from Mexico into the United States. Accepting responsibility, Leary received a thirty-seven-year prison sentence under the Marijuana Tax Act! The case was appealed on the basis that self-incrimination was required in order to comply with the Marijuana Tax Act. Leary won the case in the US Supreme Court, and in 1969 his conviction was overturned and the Marijuana Tax Act was found unconstitutional. Leary was, however, convicted of charges of drug possession and spent several years in prison. In 1970 the Weather Underground Organization, a group opposed to the government establishment, was paid to break Leary out of prison; they smuggled Leary and his wife into Algiers. Refuge had been planned in Algiers with Black Panther Eldridge Cleaver; however, this did not work out, and Leary and his wife went to Switzerland. Caught there, Leary was brought back to the United States in 1974 and received a reduced prison sentence for cooperating with the FBI investigation of the Weather Underground.

During his life Leary published many books. After a diagnosis of inoperable prostate cancer, he went on to write *Design for Death,* about new ways to think about end-of-life experiences, before his own death in 1996.

Source: Timothy Leary (2004). Retrieved on March 10, 2008, from http://www.mywiseowl.com/articles/Timothy_Leary.

After the discovery of LSD in 1943, a history of significant legal controls and drug subcultures developed. Social conditions changed after 1965, and the Food and Drug Administration (FDA) tightened regulations (Brecher et al., 1972). This was in part a response to the effects of Thalidomide, a drug given to pregnant women to prevent miscarriage that caused an epidemic of deformed babies.

In 2005, 22.4 million Americans reported lifetime use of LSD and 1.1 million reported past year use, the same figures applying to 2006 (SAMHSA, 2007a). For another hallucinogenic, PCP (phencyclidine), lifetime users totaled 6.5 million with 164,000 with past year use (SAMHSA, 2005b). In 2007, 1.1 million people used hallucinogenics within a one-year period (SAMHSA, 2008). The history of their fluctuating use in the United States is quite instructive. PCP, known as "angel dust," became notorious for its apparent increased use among adolescents. It drew considerable media and research attention over ten years ago but since then has received little media coverage and has a pattern of declining use. After considerable

use in the treatment of mental patients and alcoholics, the government ended the medical use of LSD in the mid-1960s. Recreational use led to a small number of "bad trips," which were heavily publicized. Illegal labs dispensed LSD of dubious purity and potency. Emergency room visits increased mainly owing to inexperienced users, unstable individuals, and contaminated drugs (Becker, 1967). The conditions of "good" trips included a serene situation of use, experienced guides, and reliable expectations about the drug experience.

By the early 2000s, an estimated 11.8 million had tried ecstasy (MDMA) at least once. Ecstasy is a "designer" drug—that is, a synthetically engineered drug similar to an existing illegal substance but differing enough in its molecular structure to initially avoid being classed as an illicit substance. Those who tried ecstasy for the first time in 2002 numbered 1.2 million; this number dropped to 607,000 in 2004, rose to 860,000 in 2006, and then dropped to 781,000 in 2007 (SAMHSA, 2007a, 2008). In 2004, hallucinogenic users numbering 371,000 were declared abusers or dependent, the number falling very slightly to 368,000 in 2007 (SAMHSA, 2005b, 2008). Compared with teenagers, college students, and young adults, middle-aged professionals are more likely to be controlled ecstasy users. Psychological effects of ecstasy such as confusion, depression, sleep problems, drug craving, and severe anxiety can occur during use as well as days or weeks after use.

MDMA-related arrests, 1,974 in 2001, had decreased to 764 by 2005. The Ecstasy Anti-Proliferation Act of 2000 increased sentences for trafficking by 300 percent. The criminal sanction for trafficking in 800 pills has risen from fifteen months to five years in prison, while the sanction for trafficking 8,000 pills has increased from forty-one months to ten years (Drug Abuse Warning Network, 2005). Paradoxically, as estimated use of ecstasy decreased in the early 2000s, federal seizures of dosage units climbed from 1.92 million dosage units in 2004 to more than 5 million in 2005.

Development of Cocaine Use

The Harrison Act of 1914 banned importation and nonmedical use of cocaine. It imposed the same criminal penalties for cocaine use as for opium, morphine, and heroin use. Requiring strict accounting and prescriptions for cocaine, the act classed cocaine, a stimulant, with heroin and morphine, both narcotics. *Narcotics* became the generic term for all drugs in common

parlance. Cocaine attained widespread use during two periods of US history, not because it was a narcotic but because it was a stimulant.

The first cocaine epidemic ran from 1884 to 1930. An ingredient both in coca wines and in Coca-Cola, it was marketed freely, extolled in print by celebrities, and used by movie stars and professional athletes. Thomas A. Edison and Sarah Bernhardt, a famous French actress, both used and praised the virtues of cocaine. Sigmund Freud, the father of psychoanalysis, used cocaine and claimed it was not addictive; he wrote a book describing its use and its effects, and said it was most helpful in treating a variety of ailments. However, heavy cocaine use took its toll. Heavy users became restless, disoriented, and anxious. The tide turned against cocaine, and Coca-Cola was forced in 1903 to switch from cocaine to caffeine in its recipe. More important, southerners believed cocaine triggered blacks' violence against whites. White fear of blacks only increased with newspaper exaggerations of the frequency of cocaine-induced crimes of violence (Musto, 1987).

By the time the Harrison Narcotic Control Act was passed in 1914, forty-six states had already passed laws attempting to control cocaine, evidence that it was considered the nation's number-one drug problem (Musto, 1987). However, between 1930 and 1960, cocaine use had dwindled considerably.

Drug epidemics run in cycles: prevalence rises and falls, only to rise again as a new cycle gets under way (Hamid, 1992). Generational amnesia as well as supply, demand, and drug prices all play a role in fluctuations in illicit drug consumption. During the marijuana explosion of the 1960s, cocaine reappeared on the drug scene. However, the cocaine explosion did not occur until the 1980s. Generating a good deal of "moral panic" and hysterical news coverage, it declined markedly by the 1990s. In 1985 there were 5.7 million current users, and by 1995 the number of current users had shrunk to 1.5 million. The year 2001 saw a rise among a new generation of users in the absence of great publicity (Office of National Drug Control Policy, 2007), reflecting the fact that coverage in the various media can cycle as well and not always parallel consumption—press attention decreasing while consumption is climbing and vice versa.

In 2002 there were 2.0 million current users of cocaine, 1.5 million of whom were judged to be either cocaine abusers or cocaine dependents (National Institute on Drug Abuse, 2006). In 2006, 1.7 million people were estimated to be cocaine abusers or cocaine dependent (SAMHSA, 2007a). In 2006, Americans trying cocaine for the first time within the past year numbered 977,000, up from 875,000 in 2005, with an increase to 906,000 in first-time users in 2007 (SAMHSA, 2007a, 2008). A total of 33.7 million Americans twelve years or older reported in 2005 they had tried cocaine at

least once in their lifetimes. The highest rate of current users was in the eighteen- to twenty-five-year-old age group. Men are more often current users than women. At the peak of the cocaine explosion in the late 1980s, there were almost 6 million current users of cocaine. From 2006 to 2008 current use seemed to have stabilized around 2 million users. Figures show in 2004 that 256,491 persons received treatment for cocaine abuse; in 2006 the comparable figure was 928,000; however, the number receiving treatment dropped to 809,000 in 2007 (SAMHSA, 2005b, 2007a, 2008). Statistics reflect some stabilization of cocaine use and indicate that treatment has made inroads in the established punitive response to illicit drug use, yet access to treatment remains a huge issue.

Crack cocaine became popular in the mid-1980s. Costing considerably less than powder cocaine, crack produced the desired effect as quickly and as effectively. Users obtain a rock or a brick of crack, heat it, and then smoke it in a pipe. By the time crack use had peaked, some events typical of the arrival of a new drug had already occurred. The media exaggerated its character, consequences, and extent of use. Politicians called for and got more mandatory sentences and heavier penalties. Jails soon became overcrowded, and fears of a violent crime wave mounted. A flourishing street market afforded economic opportunity to inexperienced, ambitious individual youths as well as organized gangs in neighborhoods of high unemployment. And the media claimed that a small platoon of compulsive users was actually an army of users addicted to crack, a newer and more dangerous drug than all the others (Reinarman and Levine, 1997).

The controversy over longer sentences for crack cocaine over powder cocaine continues as inner-city blacks and the poor disproportionately use crack. In the federal system, 0.18 ounce (5 grams) of crack cocaine and 18 ounces (500 grams) of powder cocaine each bring a mandatory five-year prison sentence. In 2007 the US Sentencing Commission acknowledged the disparity in sentencing and recommended lowering sentence ranges (Associated Press, 2007). This includes reducing sentences of those previously convicted. Cocaine sentencing disparities are discussed in more detail in Chapter 11.

According to the 2005 National Survey on Drug Use and Health, 7.9 million people aged twelve or older had tried crack cocaine at least once in their lifetimes (SAMHSA, 2006c). And 1.4 million reported past-year crack cocaine use. These are all increases over the 2004 National Survey on Drug Use and Health that reported 7.8 million lifetime users, 1.3 million past-year users, and 467,000 current users. While the increase indicates the initiation of a new generation of users, it still falls considerably short of the mid-1980s peak.

Development of Amphetamine Use

During the 1960s there were 14.6 million people who had used amphetamines. The 2005 National Survey of Drug Use and Health reported an estimated 10.4 million lifetime users and 1.3 million who used in the last year (SAMHSA, 2006c). The year 2006 saw considerable media coverage of methamphetamine use. Methamphetamine use reportedly has been concentrated in the Midwest—particularly in Arkansas, Missouri, and Ohio—in California, and in Hawaii (Garrity et al., 2007). Some experts cautioned about assumptions of a methamphetamine "plague" (Garrity et al., 2007). Once again, media attention to a new drug does not necessarily mean another explosion of use. The 1990s also saw a good deal of attention paid to "ice" (street term for methamphetamine) that did not culminate in high rates of use (Lauderback and Waldorf, 1993). However, the 2006 National Survey on Drug Use and Health reported that estimates of methamphetamine use are 15 to 25 percent higher than prior published reports (SAMHSA, 2007a). An important finding of the 2007 survey was that 157,000 were initiated into methamphetamine within the past year, a substantial drop from the 259,000 initiated into methamphetamine use in 2006 (SAMHSA, 2008).

From 1994 to 2004, treatments for methamphetamine abuse increased from 33,443 to 129,079 (SAMHSA, 2005a, 2005b). The Drug Enforcement Administration (DEA) reported a total of 5,393 metamphetamine-related arrests in 2004. Most arrests have been for trafficking. On the assumption that treatments outnumber arrests, the social response to methamphetamine abuse would appear to be more therapeutic than punitive in contrast with responses to traditional narcotics.

President Nixon declared the first "war on drugs" and established the DEA, the federal agency in charge of the nation's drug policy and its enforcement. Congress passed the Controlled Substances Act and established the National Institute of Drug Abuse (NIDA) in 1970. By the 1970s the DEA had become the major bureaucracy coordinating the operation of a host of national agencies dealing with drugs. This marked the dominance of the punitive over the public health approach to drug control. Passage of the Controlled Substances Act in 1970 classified drugs that had some or no medical use, as well as their potential for abuse. In the early 2000s the DEA's budget still was four times that of NIDA and the country continued to adhere to a "hard on drugs" policy.

While in the past it was more common to abuse one substance, most substance abusers and addicts, at this writing, use multiple substances (see Box 1.3). However, all users tend to have a drug of choice.

Box 1.3 Dan's Entrée into Substance Abuse

Dan, age twenty-one, was serving seven years in prison for armed robbery. Here is what Dan had to say about the development of his substance use:

> I started smoking pot when I was about 15, something like that. I started taking acid and from acid, ecstasy to drugs like that. Then, all of a sudden someone introduced me to heroin and I was takin' that now and again and then crack came along and that was it. It all went haywire . . . it's addictive . . . you get a rush, you blow the smoke out, but it's only for a couple of seconds, then it's gone . . . then you feel stressed out and paranoid. . . . It was crack and heroin 24-7 (24 hours a day, 7 days a week). I'd wake up in the mornings and when I was smokin' crack and needing heroin, takin' heroin to sort of take the bad one away, level your head a bit. (Cope, 2006, 288)

Drug Classification and Scheduling

Classification of drugs is complicated and confusing. It is perhaps easiest to understand by examining a threefold classification of drugs. First, controlled substances are defined from the point of view of drug control, especially by the federal DEA. While the federal government approves the scheduling (categorizing) of drugs, it is not without controversy. For example, the classification of marijuana as a Schedule I drug with a high potential for abuse and no medical use calls the scheduling of drugs into question.

Second, drugs can be classified by pharmaceutical companies and those that develop them, as well as by those who prescribe and dispense them, such as physicians and pharmacists. These classifications include stimulants and depressants, discussed in Chapter 3. Third, there is the classification of effects by users. Street terms give some indication—"Special K" for ketamine and ecstasy for MDMA, both dissociative drugs. These names address the significance of the subjective experience of drug use. That is, effects vary for a variety of reasons, including history of use, tolerance, purity and potency of the drugs, the circumstances under which drugs are used, and whether multiple drugs are used. The first classification, the federal scheduling of drugs, is discussed in this section. The second and third classifications are discussed in Chapter 3.

The 1970 United States Controlled Substances Act regulates the availability of drugs as part of the Comprehensive Drug Abuse Prevention and Control Act of 1970. Five schedules, or categories, of controlled substances were developed and are reviewed and updated on an annual basis (DEA, 2008). Tobacco and alcohol are not included in the scheduling of

drugs, an interesting point, since both are the most widely abused drugs and cause the most significant medical problems.

As indicated, drug scheduling, through state and federal efforts to categorize drugs, is a mechanism to assist in determining legal sanctions for illicit sales and possession of drugs. The severity of sentences for drug violations is related to both the schedule of the drug and the amount of the illicit drug. Drug scheduling is therefore an important part of the US government's effort to control and combat drug abuse. *Schedule I* drugs have no currently accepted medical use in the United States and are drugs deemed to have high potential for abuse. Examples include heroin, LSD, mescaline, ecstasy, and gamma hydroxybutyrate (GHB). Marijuana—the most popular and frequently used of the illicit drugs—is also classified as a Schedule I drug. Controversy continues to swirl around the appropriate use of marijuana in the treatment of cancer and other health problems. The DEA insists that it remain a Schedule I controlled substance, and the Supreme Court ruled in 2005 that no exception could be made for the medical use of marijuana. Consequently, the eleven states that permit such use of marijuana are in conflict with federal law. (See Chapter 14 for a full discussion of medical marijuana.)

Schedule II drugs have a currently accepted medical use, although they have a high potential for abuse and severe psychological or physical dependence. These drugs include cocaine (accepted use is as a topical anesthetic), morphine, phencyclidine (PCP), opioid agonists, methadone, short-acting barbiturates, and amphetamines, including methamphetamine. Ritalin, prescribed for the treatment of attention deficit hyperactivity disorder (ADHD) in children, is a Schedule II drug. OxyContin, the powerful pain reliever, well-known for its abuse potential, is also a Schedule II drug.

Schedule III drugs have currently accepted medical use and low to moderate risk of physical dependence but high risk of psychological dependence. This classification includes anabolic steroids (used by some athletes), ketamine (a veterinary anesthetic, which is also a club drug—often used in clubs), marinol (derived from marijuana for pain control), and buprenorphine (a relatively new drug used in the treatment of addiction).

Schedule IV drugs have relatively low potential for abuse and have a currently accepted medical use. These include benzodiazepines such as Xanax, Librium, Valium, and others prescribed for anxiety and as a sleep aid. Also here are the long-acting barbiturates such as phenobarbitol.

Schedule V drugs have an even lower potential for abuse and have medically accepted uses. Sometimes Schedule V drugs are available without prescription. Examples include cough suppressants with codeine and preparations to treat diarrhea that may include opium (DEA, 2008).

We begin to see that the social environment and characteristics of drug users affect the reaction of society. In turn, this has an impact on the possible sanctions for substance abuse and addiction.

The Drug Legalization Debate

Considerable federal and state financial resources are spent enforcing drug policies, typically divided into enforcement, prevention, and treatment efforts. Drug-related arrests have been up considerably since the early 1990s, as have been drug-related incarcerations. Support for drug laws has been strong because many people feel they serve a protective function, especially for children. Yet the consequences are enormous, with urban minority communities bearing the brunt of law enforcement efforts and high incarceration rates (Boyum and Kleiman, 2003).

Enforcing drug laws has always placed enforcement agents at risk of employing questionable methods of interrogations, entrapping drug violators, and paying informants with drugs. Drug-war reformers have questioned disparities in penalties for powder versus crack cocaine, in arrests of minorities, and in the preponderance of arrests for marijuana relative to such drugs as cocaine, heroin, or synthetic opiates. Advancement in the policing ranks, going from beat cop to detective, can depend on production of arrests. Such production depends greatly on obtaining information in ways the law forbids and police culture finds acceptable (Conlon, 2004).

Some use the terms *legalization* and *decriminalization* interchangeably; however, there is a distinction (Bretteville-Jensen, 2006). Decriminalization can be seen as a compromise or "halfway step" between drug prohibition and drug legalization (Faupel et al., 2004). Decriminalization removes criminal sanctions although there may still be civil sanctions such as fines. Some who favor decriminalization want to decriminalize marijuana and leave sanctions intact for selling and distributing drugs such as cocaine and heroin. Others who support legalization recommend treating drugs the same way as alcohol—regulating the sale and consumption. Another interpretation of legalization is letting market forces decide the price of drugs.

Those who support decriminalizing or legalizing all drugs as well as those who support harsh drug laws ask the question: "Do drugs, or drug laws, cause crime?" (Boyum and Kleiman, 2003, 21). The answer appears to be "yes" to both. Intoxication and addiction can certainly increase crime due to the pharmacological effects and the economics of buying and selling. It is well-known that drug laws contribute to crime by creating black markets (Bretteville-Jensen, 2006). With legalization, prices fall and this

can reduce crime; however, it is likely the number of drug users will increase, at least in the short term. The concern is that a great proportion of the population becomes at risk if currently illegal drugs become available (Inciardi, 1996). Research reflects the majority of economists support drug legalization and overall public support for legalization has grown over the last ten years (Thornton, 2007). See Chapter 11 for a detailed examination of the relationships among alcohol, drugs, and crime.

While drug policies cannot ensure a drug-free society, there are certainly opportunities to create a safer society (Boyum and Kleiman, 2003). As we will explore in this text, policy changes may include raising alcohol taxes, redirecting criminal justice resources to severe drug-related violence, and expanding the availability of voluntary and compulsory substance abuse prevention and treatment programs, especially those in the criminal justice sphere (Inciardi, 1996). The politics of science is at work as well. Needle exchange programs have shown their effectiveness in reducing the spread of HIV/AIDS (human immunodeficiency virus/acquired immunodeficiency syndrome), yet the public and politicians remain critical of them (Sherman, 2006). The future of US drug policy is discussed in the final chapter.

Conclusion

What is old and what is new about early twenty-first-century illicit drug use and social responses? The punitive response—mandatory sentences and harsh penalties—persists. Prisons continue to be crowded with nonviolent drug violators. A small number of highly visible drug users are more likely to be arrested than the large number of people who use drugs. Physicians are more likely to treat the less visible users and more likely to medically addict them through overprescribing. Enforcement agents are much more likely to arrest blacks and Hispanics for marijuana possession in urban areas where there are higher concentrations of minorities. And agents continue to pay close attention to the number of drug prescriptions physicians write, just as they did after passage of the Harrison Act in 1914.

Smuggling drugs will continue as a lucrative economic pursuit. New drugs will come on the market, and enterprising experimenters will find addictive uses for many of the new and some of the older pharmaceuticals. While the drug policy establishment of the early 2000s is not likely to fade away, treatment will continue to show steady incremental increases if financial resources are available. Not surprisingly, the drug prohibition versus decriminalization and legalization debate will go on.