

Module 1: Alcohol, Drugs and Society

Welcome!

- A few important questions to answer:
- Who am I?
- Who are you?
- Why are we here?
- How will this semester work?

Who are you?

- Post on the Introduction discussion board
 - *Name*
 - *Year in School; Major (and minor)*
 - *Previous Sociology Courses (if any)*
 - *Two Interesting Things About Yourself*
 - *One or Two Questions that you would like me to answer about myself*
- Initial posts for discussion boards are due Tuesday, reply due Friday*
 - *because of drop/add, I will not hold folks accountable on these specific dates this week, but good to get in the rhythm now



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Participation Question

- From what you know or have heard, what do you think happened to alcohol consumption during the Prohibition era?
- Note: Just a 'gut-level' answer to add to your introduction post. Usually, I want you to read and reflect prior to a discussion board post, but this is an exception.
- Also, if you have personal reasons for being interested in the study of drugs and alcohol, please consider sharing in your introduction.

Why are we here?

- Why study alcohol and drugs in a sociology course?
 - The use of mood and mind-altering is a source of considerable conflict in the U.S.
 - Alcohol and drug use always exists and develops in a social context.
 - Sociology is not psychology, criminal justice, or social work;
 - Sociologists examine drinking and drug problems as products of socially organized activity and shared understandings.
 - Social facts have policy implications.

How will this semester work?

- Syllabus
 - Our road map for the semester
 - Be sure to read it and understand it!
 - Know your syllabus day!
- Getting Acquainted Quiz (due Friday*)
- *again, because of drop/add I will give grace this week, but these will be our due days throughout the semester!



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Module 2: History of Drug Use in America



Caution: Myths Regarding Drug Use are Widespread

- Why?
- Mental shortcuts often lead us to draw false conclusions
 - Judgmental heuristics = flawed, informal rules of thumb people use to reach conclusions
 - Availability heuristics = the tendency to believe that phenomena that readily come to mind or are especially vivid or dramatic are more common or frequent than they are
- Media depictions of drug use can exacerbate these problems

Sociologists love to debunk myths and stereotypes

- Exploring alcohol consumption through U.S. history provides an excellent opportunity to see historians and sociologists debunking accepted myths.

MYTH

- **FIRST MYTH:** Alcohol was consumed less in colonial America than it is today.
- **FACT:** Alcohol consumption per capita was almost 3 times as high in colonial America as it is today

Fact: Colonial Puritans drank plenty of alcohol

- "One of the things we understand now is that the initial ship that came over from England to Massachusetts Bay actually carried more beer than water."
- "Early Americans...took a healthful dram for breakfast, whiskey was a typical lunchtime tippie, ale accompanied supper and the day ended with a nightcap. Continuous imbibing clearly built up a tolerance as most Americans in 1790 consumed an average 5.8 gallons of pure alcohol a year."
- From "The Time When Americans Drank All Day Long" by Jane O'Brien, <https://www.bbc.com/news/magazine-31741615>



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Myth: Johnny Appleseed grew tasty apples people ate

- His apples weren't eaten...were known as 'spitters' because they tasted bad. Apples are 'heterozygotes,' requiring farmers to 'graft' edible varieties rather than grow from seed, yet Johnny Appleseed planted from seed.
- Why, then, did Johnny Appleseed plant apple trees?
- "Up until Prohibition, an apple grown in America was far less likely to be eaten than to wind up in a barrel of cider. In rural areas, cider took the place of not only wine and beer but of coffee and tea, juice, and even water."

Another Common Myth: Alcohol Consumption Increased During Prohibition in the 1920s

- **FACT:** Alcohol Consumption was cut in half during National Prohibition
 - from about 2 gallons to 1 gallon of absolute alcohol per capita (per person)
- Key point from our reading for this week! There are ways in which national prohibition can be viewed as a Public Health innovation (and success.)
 - For instance, the death of the 'saloon' and the virtual destruction of the liquor industry ('Big Liquor').
 - Decrease in number of deaths from cirrhosis of the liver.



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Alcohol Consumption did not fully rebound until decades later

- Decreases in alcohol consumption did not immediately go away, as consumption remained lower than pre-prohibition until the 1970s
- “Following repeal of prohibition, although annual consumption rose, to about 2 gallons per capita in the 1950s and 2.4 gallons in the 1960s, it did not surpass the pre-Prohibition peak until the early 1970s”

Nuancing Our Understanding

- The largest decline in alcohol consumption occurred in the mid-1800s, NOT during national prohibition. This highlights the importance altering **cultural mores** due to the Temperance Movement
 - Movement also passed political laws at local and state level—which often involved less drastic enforcement modes than federal prohibition
 - Still, movements have cultural and educational impacts beyond just laws
- Prohibition's decreased alcohol consumption was gone by the 1970s, yet new declines in alcohol consumption occurred in the 1980s, illustrating the need for continued exploration of both cultural and political shifts

Exploring Drug Control Legislation: Important Nuances in Legislating National Prohibition

- Federal prohibition went much farther in the direction of banning personal consumption than all local prohibition ordinances and many state prohibition statutes.
- The 18th amendment forbade the sale and distribution of “intoxicating” beverages, but most brewers of beer expected that beer, with its lower alcohol content would be allowed. They were stunned when the Volstead Act prohibited beer as well.
- Still, focusing on sale and distribution meant private consumption was permitted, and sacramental wine and medicinal liquor as well.

Studying Trends Over Time

- One of the most interesting issues a sociologist or criminologist addresses is trends in drug use over time
- To identify and analyze trends, we need valid, reliable, and systematic data.
- Systematic data = data that were gathered in a planned fashion and represent an accurate view of the phenomenon under study

Lack of Systematic Data Hampers Analysis of Trends Over Time

- Beyond Alcohol and Tobacco, we have limited quantitative data on drug use prior to the 1960s.
- Even for Alcohol and Tobacco, we are generally limited to consumption data calculated from taxes (with considerable potential for measurement error)
 - Note: Data for alcohol consumption during prohibition must be estimated, since taxes were NOT collected (but tax collections just before and just after prohibition provides a basis for concluding that consumption was halved).
- With the emergence of large-scale surveys in the early 1970s, sociologists and criminologists began exploring trends on many more drugs and with more measures



Drug Use Trends Over Time: 1960s to 1979

- Retrospective estimates = calculations, based on the recall of interviewees and indirect indicators, of drug use during earlier periods of time (were used to estimate drug use in 1960s)
- The 1970s represented a kind of high point of tolerance toward use
- This growing tolerant attitude was translated into legal policy during the 1970s
- During that decade 12 states decriminalized the possession of small quantities of marijuana
- Legislators sensed more public acceptance of at least one illicit drug and implemented that perception into legal policy, voting to remove criminal penalties for small quantity possessions

Drug Use: The 1980s to the Twenty-First Century

- Two remarkable events during the 80s and 90s:
 - In the decade or so after drug use's high point (1978-1980), it experienced a sharp decline
- During the early 1990s, drug use seemed to be on the rise again
 - However, the biggest increases in drug use after the early 1990s took place among the very young – segments of the population whose use had only recently begun to be recorded.
 - In the brief span of just five years between the early to the mid-1990s, recent or current illicit drug use had more than doubled among an extremely vulnerable adolescent segment of the population.
 - Initiation into the use of illicit substance was beginning to take place at earlier and earlier ages.
 - However, for many of the “club drugs,” this increase was short-lived and has since receded
 - One real shift in use involved misuse of prescription drugs—narcotic pain-relievers, in particular.



Drug Use Today

- Drug use in the 21st century, despite many voices to the contrary, has shown much more consistency than change.
- One important change is the growth of overdose deaths due to narcotics.
 - 3 waves of increases related to prescription opioid misuse, then increase in heroin deaths, and finally recent large increases in overdose deaths due to the emergence of Fentanyl-laced drugs. Fentanyl is exceptionally potent narcotic.
- *All illicit drug overdose deaths* rose from about 20,000 In 2000 to an estimated 107,622 drug overdose deaths In 2021
(https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2022/202205.htm)

Drug Use Today

- Still, more deaths are attributed to legal drugs than to all illegal drugs put together
 - Cigarette smoking is responsible for more than 480,000 deaths per year in the United States
(https://www.cdc.gov/tobacco/data_statistics/fact_sheets/fast_facts/index.htm)
 - Excessive alcohol use was responsible for more than 140,000 deaths each year in the United States during 2015–2019
(<https://www.cdc.gov/alcohol/features/excessive-alcohol-deaths.html>)

Rates and Patterns of Drug Use: The Basics

- There are several important concepts for understanding rates and patterns of drug use:
 1. Prevalence Rates
 2. Continuance (or “loyalty”) Rates
 3. Consumption Levels—what we explored in the earlier graphs and discussion of the history of alcohol use
 4. New Initiation of Use and Life Cycle Rates

1. Prevalence Rates

- Prevalence rate = the percentage of a given population that has used a specific drug within a specific time period
- Many commentators discuss illicit drugs as if the use of each and every one were precisely equivalent, whereas the number of users that different drugs attract varies considerably
- Prevalence rates can be measured by lifetime, past year, or past month use
- Alcohol (a *legal* drug) is the most popular of all psychoactive substances
- Of all illicit drugs, marijuana is the one used by the greatest number of people – and by a considerable margin



2. Continuance Rates

- Continuance Rate = for a given drug, a figured calculated by comparing the proportion of at-least-one-time-users who have also taken that drug within a more recent time period, usually during the past month
- The number of people who have ever used a given drug is less important than the number and proportion who use it regularly
- Continuance rate is one of the most important features of a drug's pattern of use

Continuance or 'Loyalty' Rate

- Drugs vary with respect to user loyalty
 - Alcohol generates the strongest or greatest user loyalty
 - Of illegal drugs, marijuana generates the strongest user loyalty
 - As a general rule, legal drugs have higher continuance rates than illegal drugs.
 - In the past, people sometimes referred to this as 'habitual use potential'

Continuance or 'Loyalty' Rate

- How are drug use continuance rates measured?
 - Usually compares lifetime use with use in the past month
 - A slightly different (and less often used) continuance rate can be obtained by comparing the use of a given drug in the past year with use in the past month; with this alternative calculation, tobacco exhibits the highest continuance rate
- General Pattern: The more deviant or illicit the drug, the more that users discontinue its use, or use it sporadically; the more conventional or licit the drug, the more that users continue its use and take it regularly.

3. Consumption Levels

- Consumption levels = the total volume of a given drug that is used during a given time period
- A given drug may be widely used (prevalence rate) but not necessarily heavily used (consumption level)
- Far more people drink alcohol than smoke tobacco cigarettes, but people consume far more doses of tobacco. Average drinker consumes ~2 drinks/day, whereas the average smoker consumes ~15 cigarettes/day.
- Key Conclusion from Sociological Research: Legalization is more likely to influence consumption levels than prevalence rates (people still try illicit drugs, but they tend to consume much less of it)

4. New Initiation of Use and Life Cycle Rates

- Vast majority of people begin using new drugs prior to age 25, especially true for legal drugs
- For instance:
 - among people aged 12 or older in 2020, 1.3 million people initiated cigarette smoking in the past year (i.e., never smoked cigarettes before the past 12 months)
 - Relatively few people (approximately 10 percent of past year initiates) tried cigarettes for the first time after age 25. For alcohol, % was even smaller, (5% of initiates were over age 25).
 - For marijuana, the percentage of new initiates over the age of 25 was about 25%, and for cocaine, it was about 15%



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Life Cycle Rates

- Life-Cycle rates = varying likelihoods of using drugs at different ages in the life span.
- In spite of slight variations, for at least three decades, drug use has been, and remains:
 - relatively low among youth (12 to 17),
 - extremely high among young adults (18 to 25),
 - even lower in the older adult years (26 to 34),
 - and lower still after the age of 35.
- Occasionally the media reports (often without a strong basis) that drug use has become uncharacteristically high among an age segment of the population not typically given to high rates, this may simply signal an earlier initiation of use
- Illegal drug use is strongly related to age, whereas legal drug use is spread more evenly throughout the life-cycle.
- Drug use begins at a low point, rises in early adulthood, and declines fairly steeply after that



Module 3: History of Drug Control In the US

Transformative Era in Drug- Historians argue that 1800s were likely the highwater point for drug use in the U.S.

- Sociologists refer to natural, transformative, and synthetic eras of drug use.
 - The natural era began in pre-history as early communities used a variety of substances to alter mood and mind
 - The transformative era began in the 1800s as morphine, codeine, and cocaine emerged alongside technological advances, such as hypodermic needles and international trade, that made drug use more available and more prevalent!
 - Synthetic Era began in the 1900s as drugs created entirely in labs became available

Drug Use in 19th Century America: Medical, Scientific, and Technological Innovations

- An explosion of scientific, medical, and technological innovations during the 1800s made psychoactive substances not only more available, but available in purer form, and via a much more efficient and effective route of administration
- Morphine, a much more potent narcotic, was extracted from opium in 1803. Codeine, another derivative of opium, was synthesized in 1831.
- Hypodermic syringe devised in Europe, and brought to U.S. in 1856; soon made its way into doctor's offices/homes
- In 1859, cocaine was isolated from coca leaves.



The 1800s- A National 'Laissez Faire' Approach to Drug Control

- Psychoactive substances freely available from a variety of sources; consumption immense
- Opium, initially, **viewed as godsend by the medical community and patients**
 - However, opium usually masked symptoms instead of curing the problem and left patients with addictions.
- Over-the-counter medications containing opium, morphine, marijuana, and cocaine freely available throughout 19th century without a prescription
- Prior to 1906, manufacturers did not even have to list ingredients on products
- In the 1890s, some laws were enacted requiring prescriptions, but they weren't enforced.

In the 1800s, Drug Use Was Not Uniform in the U.S.

- Indeed, as it often does today, drug use varied immensely by region, class, religion and race.
- For instance, from one of our readings this week:
 - “With the possible exception of the Chinese, southern whites had the highest addiction rate for opiates of any regional racial group in the country, and perhaps one of the highest in the world. At the same time, southern blacks had a relatively low rate of addiction, at least with respect to opiates. Blacks, when they used drugs at all, tended to use cocaine.” (Courtwright, 1983)
- Different groups of users were viewed very differently by legislators and, as a result, were impacted very differently by national (and local) legislation as well!
- Efforts to stem tide of substance abuse complicated by mixed motives of reformers (Public Health concerns, yes, but also racism, religious bigotry, and classism as important factors).



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Mainly Exploring Federal Legislation in this Module

- Legislative efforts at the local and state level often emerged prior to national efforts to control drugs
 - However, it is too difficult to highlight shifts in 50 different legal regimes, so I will prioritize a discussion of federal regulations
- Because legislation never occurs in a vacuum, a discussion of the movements and situational contexts that shaped these laws is essential

First National Legislative Step: The Pure Food and Drug Act of 1906

- Pure Food and Drug Act = a federal law, passed in 1906, that required distributors to list the ingredients of a product on its packaging
- Act did not outlaw the sale of patent medicines that contained opiates and cocaine; simply required that contents be listed on label
- Labeling combined with media exposure brought about keener public awareness of lack of curative powers of so-called medications

Drug Use in 19th Century America: Cocaine-Based “Soft” Drinks

- Wide variety of beverages sold during 19th century contained psychoactive substances, mainly cocaine
- John Pemberton, an Atlanta pharmacist and patent medicine vendor, introduced Coca-Cola – syrup containing caffeine and extracts of coca leaves
- <https://www.youtube.com/watch?v=FYp0C62R1KA>
- Notice by 1906, owners/distributors of Coca-Cola had given into pressure to decocainize the soft drink

Early Anti-Opium Legislation

- Earliest laws not aimed at medical addiction but at recreational use
- Local and State Laws specifically targeted Chinese immigrants who settled California in 1840s and 1850s to work on railroads and goldmines
- Whites threatened by presence of Chinese; feared influence on young people, particularly females
- 1909 – Smoking Opium Exclusion Act (Initial Federal Legislation, but weak and focused on Chinese smoking of opium, rather than other opiates)
 - See “Racism’s Hidden History in the War On Drugs” (https://www.huffpost.com/entry/war-on-drugs_b_2384624)



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Next Critical Federal Legislation: The Harrison Narcotics Tax Act, 1914

- Harrison Act = a federal law, passed in 1914, that required a prescription written by licensed physicians to be obtained for the sale of narcotics and cocaine, and that such sale be registered, recorded, and taxed (See reading for this week: Preventing and Treating Narcotic Addiction- A Century of Federal Drug Control)
- The Act did not directly criminalize addiction per se, but during a series of Supreme Court rulings between 1919 and 1923, maintaining the addict on a narcotic was declared an improper medical practice and hence, illegal
- By mid-1920s, medical profession had withdrawn from dispensing narcotics to addicts

Situational Context: The Shanghai Commission and the Hague Committee

- Opium Wars = the wars (1839-1842 and 1856-1860) fought by Great Britain to force China to open that country to the opium trade, which China had outlawed
 - A half-century later, however, the U.S. (and UK) sought the exact opposite!
- The International Opium Commission (a.k.a., the Shanghai Commission) held in China in 1909; convened reps from 13 countries
- The International Conference on Opium (a.k.a., the Hague Conference) held in the Netherlands in 1911; reps from 12 nations
 - Pushed other countries to pass laws; led to questioning of why U.S. did not have its own legislation
 - In response, Harrison Act developed and passed

Impact of the Harrison Act: Did It Make Things Worse?

- Many observers argue that the changes in the addict's legal status, shaped in large part by the Harrison Act, produced our current, extremely serious, drug problem and links with criminality
- Labeling Theory- By making narcotics illegal, users were labeled as criminals (and this pushed many to become so)
- But Consider:
 - Majority of early 1900s addicts were medical addicts – white, middle-class, middle-age women
 - Majority of post-Harrison Act addicts were street criminals – inner-city males
 - Labeling Theory is not so powerful that it was turning medical addicts into criminals, and also turning women into men!



Next Legislative Act:

National Prohibition of Alcohol- 1920

- Volstead Act (a.k.a., National Prohibition Act) = national legislation specifying enforcement of the the 18th Amendment, which outlawed the sale and distribution of alcoholic beverages in the U.S. – empowered the federal government to enforce the law
- Volstead Act a triumph of Protestants over Catholics, native-born Americans over immigrants, rural and small town dwellers over urban residents, the South over North, farmers and the middle class over the working class, Republicans over Democrats, etc. (Another example of “Conflict Theory” why?)

Long Historical Context: The “Temperance Movement”

- Early beginnings, Dr. Benjamin Rush, Philadelphia physician publishes *An Inquiry into the Effects of Ardent Spirits on the Human Mind and Body* (1784), first discusses alcoholism as a disease
- Sermons and publications began to have impact on American drinking patterns: workers fired for drinking on the job, troublesome taverns closed down or had their licenses revoked, etc.
- By the mid-1800s, hundreds of antiliquor organizations emerged throughout country, and alcohol use had already declined substantially



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The “Temperance Movement”- Late 1800s and Early 1900s

- Women’s Christian Temperance Union (WCTU) organized in 1874 – single most powerful late 19th century antiliquor lobby
 - Why were women, Christian reformers so important? (links to progressive movements for abolition and women’s rights)
- Urban saloon became target of prohibitionists (links to ‘macho’ culture, violence and criminality)
- Anti-Saloon League organized in 1893 – major political force; single purpose is national prohibition; Lobbied in ways that successfully exploited divide between Southern and Northern Democrats
- Despite prohibition’s earlier links to progressive reform, it also relied on nativistic appeals emphasizing immigrant Catholics, especially, as drunks and sources of social problems...Again, highlighting mixed motives of reformers

Recall from Last Week:

Nuances in Legislating National Prohibition

- Federal prohibition went much farther in the direction of banning personal consumption than all local prohibition ordinances and many state prohibition statutes.
- The 18th amendment forbade the sale and distribution of “intoxicating” beverages, but most brewers of beer expected that beer, with its lower alcohol content would be allowed. They were stunned when the Volstead Act prohibited beer as well.
- Still, focusing on sale and distribution meant private consumption was permitted, and sacramental wine and medicinal liquor as well.
- “Rules for thee, not for me”- Some early sociologists went through trash to document how upper-class WASP proponents of prohibition often continued consuming alcohol, yet emphasized enforcement of non-consumption on working class folks who were unable to ‘stock-up’ prior to ending of sales



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Repeal of National Prohibition- 1933

- With the onset of the Great Depression, then the election of FDR in 1932, the stage was set for the repeal of national prohibition.
- With repeal in 1933, the consequences of ending prohibition enforcement and generating economic activity (through the redevelopment of the liquor industry) were obvious and intended, but there were also less obvious, non-intended consequences.
- For instance, the federal enforcement apparatus (though inadequate to successfully enforce alcohol prohibition without state's help) sought to find new purposes to maintain its existence
 - The head of the agency: Harry Anslinger went from arguing that marijuana was not a concern in the early 1930s to the strongest, single proponent for the Marijuana Tax Act.

The Marijuana Tax Act, 1937

- FBN, under leadership of Harry Anslinger, undertook a major media campaign and lobbied in legislatures to convince the public of the evil effects of marijuana
- Marihuana Tax Act = a federal law, passed in 1937 and modeled after the Harrison Narcotic Tax Act
 - NOTE: The tax was set so prohibitively high, that it was never intended to bring in any income.
- Instead, through the Act, the government effectively banned all possession and sale of marijuana products

The Nixon Administration Enacts the Controlled Substances Act

- The **Controlled Substances Act** (1970) increased funding for the Public Health Services hospitals; authorized the National Commission on Marihuana and Drug Abuse, a detailed, wide-ranging study of drug use; and established penalties for the possession and sale of drug categories or schedules
 - Initially focused on research and rehabilitation
- Superseded and replaced all prior federal drug legislation

Rhetoric vs. Substance

- Nixon is the only recent president whose record reflected a stronger domestic commitment to **rehabilitation and treatment** than to enforcement
 - Especially in grappling with extensive heroin use among those involved in the Vietnam war
- Fascinating discussion with Nixon Appointee
<https://www.pbs.org/wgbh/pages/frontline/shows/drugs/interviews/jaffe.html>
- Despite evidence that methadone programs worked, public mood began swinging away from treatment and toward punishment
- After his reelection in 1972, Nixon went along with those demanding more punitive drug legislation/penalties for drug offenses; Indeed, he coined the term “War on Drugs”
- Reality challenges the view that Republican=Drug War Hawk, Democrat=Drug War Dove; these ‘on average’ differences between political parties did not become large until the 1990s or even later

Ford Administration

- August 1974 – Nixon resigns presidency due to Watergate scandal; Gerald Ford, Speaker of the House of Representatives, becomes president
- Ford had little interest in drug problem, even less interest in drug treatment
- Federal support for treatment programs begins to decline; funds reverted to enforcement
- Tidal wave of drug incarcerations about to begin

The Backlash Gathers Strength: The Carter Years

- The 1970s is the time period where levels of drug use generally peaked, and 12 states decriminalized the possession of small quantities of marijuana
- Carter elected in 1976 and comes out in favor of marijuana decriminalization (in accord with the opinion of young Americans)
- In the late 70s, Martha Schuchard and a neighbor formed Families in Action, dedicated to fighting teenage drug abuse.
 - During the 80s and 90s, the pro-parent, antidrug movement became the most powerful nongovernmental force influencing drug policy.
- The beginnings of a shift towards enforcement, which shaped the final Nixon/Ford term, also impacted Carter's administration



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The Reagan Years

- A dramatic rise in incarceration for drug offenses began in 1980, coinciding with Reagan's (a staunch conservative) election.
- Under Reagan, the "War on Drugs" was rejuvenated and the foundation of the current drug policy was laid.
- Whereas Nixon's war on drugs stressed treatment, Reagan emphasized enforcement. Hence, any story on "drugs as crime" begins in the Reagan era.
- Reagan's drug advisor, Carlton Turner, was a conservative who rejected distinctions between hard and soft drugs and hardcore and recreational users. He believed treatment sent the message that drug abuse was acceptable.
- First Lady Nancy Reagan adopted the antidrug mission and formed the Just Say No Club for schoolchildren.

The Reagan Years: Bi-Partisan War On Drugs

- 1986: NYC mayor Ed Koch (Democrat) proposed the death penalty for any dealer convicted of possessing a kilogram of heroin or cocaine. Shortly after, Governor Mario Cuomo (Democrat) called for a life sentence for anyone convicted of selling three vials of crack (at the time, about \$50 worth).
- Reagan called for legislation totaling \$2 billion in federal monies to fight the drug problem.
- The Anti-Drug Abuse Act of 1986 introduced minimum sentences for cocaine possession. Remarkably, the bill had a 100-to-1 discrepancy between the volume of powder versus crack cocaine necessary to draw a 5- to 40-year sentence. The penalty was the same for possession of five grams of crack as for 500 grams (just over a pound) of powder cocaine.
- The Anti-Drug Abuse Act of 1988, which called for the death penalty for major traffickers and penalties for dealers. The bill stated that “illicit drugs are harmful” and “no drug use is recreational.”



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Some Reflections

- Most of what happens in drug enforcement takes place at the state rather than federal level, but the president influences the national mood.
- Nixon rhetorically launched the War on Drugs, and Reagan supercharged it. Bush Sr. continued the war and Clinton increased federal spending to control drug abuse ten-fold, along with arrests.
- In 1980, drug offenders made up 19% of all federal prisoners; in 1990, this figure increased to 53%. (But state and local prisons hold 4/5 of all prisoners)
- During the second administration of George W. Bush and Barack Obama's terms, the political climate became less punitive and more treatment-oriented.
- The "lock 'em up and throw away the key" mentality had abated.
- In terms of policy, the "First Step Act" criminal reform act passed in 2018 during the Trump administration continued this shift away from mass incarceration. However, Trump's rhetoric (like that of Nixon) tended to be at odds with this policy as he amped up 'law and order' rhetoric during his presidency. State legislative action on Marijuana legalization has been an area of increased policy engagement, but this has not yet translated to the national stage

Who Drinks? Who Doesn't?

- Drinking positively related to social class or socioeconomic status (SES) – the higher the income, education, and occupational prestige, the greater the likelihood that someone will drink
 - However, upper-SES persons more likely to drink moderately than lower-SES persons
- Men more likely to drink than women – men also drink at greater volume
- Young adults under the age of 35 most likely to drink – likelihood of drinking declines with age (slowly)

Module 4: Theories of Drug Use

Theory

- Theory = a general explanation, whether confirmed or unconfirmed, of a broad class or category of phenomena; a theory of drug use would attempt to explain why people, or some people, use or abuse psychoactive substances
- Nearly all theories are partial in scope – select one or a limited number of factors that are believed to cause drug use and abuse
 - Most (not all) theories cover different aspects of the same phenomenon
 - Thus, theories can be complementary, rather than contradictory

Toward Biopsychosocial Explanation

- Our reading for this week discusses the micro-macro divide within sociology and attempts to bridge these theories
- In this powerpoint, we explore another division—between biological, psychological, and sociological theories.
- It is important to consider how all these different factors might lead to a cumulative biopsychosocial form of explanation
- Because this is a sociology course (and sociology is my area of expertise), we spend more time on sociological theories and, importantly, highlight criticisms of prior biological and psychological approaches.
- Researchers must actively seek to bridge these divisions, though. This does not mean dismissing criticisms, but it means seeking explanations that, responding to existing criticisms, improve on prior explanations.



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Biological Theories

- Biological theories (of drug use) = based on physical causes, such as genes, hormones, neurological factors, etc.
 - Postulate that specific physical mechanisms in individuals impel or influence them either to experiment w/ drugs or to abuse them once they are exposed to them
- 2 such theories:
 - 1. Metabolic imbalance
 - 2. Genetic theories

Classic Model of Physical Addiction

- Dominated the field of drug studies until the 1970s
 - Studied rats who were provided heroin-laced water
 - After awhile, removal of the heroin-laced created physical withdrawal symptoms (shakes, unkempt physical appearance, physical deterioration and even starvation)
 - Indeed, if physical dependence was high enough with heroin, the rats would die from withdrawal. However, if they were provided with the heroin-laced water, then their symptoms went away, and health improved.
- Recognizes the existence of cross-dependence
- Administration of a drug that is cross-dependent with the addicting drug can be used to alleviate withdrawal
 - Basis for methadone maintenance programs in the 1970s (see again, <https://www.pbs.org/wgbh/pages/frontline/shows/drugs/interviews/jaffe.html>)



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Metabolic Imbalance Theory

- Metabolic imbalance = theory focuses specifically on narcotic addiction; proposes that opiate addiction is caused by an incomplete biochemical makeup, which narcotic drugs completes
- Once persons with a metabolic imbalance begin using narcotics, a biochemical process kicks in to make their bodies crave opiate drugs and render them prone to becoming addicts
- No biological mechanism corresponding to metabolic imbalance has ever been found
 - This has led to the theory's relative decline (it remains unproven, though not disproven). Consequently, arguments for lifelong methadone maintenance approaches have become less persuasive, yet some still argue for this approach. Shows how theory and policy debates are inter-related!

Genetic Theories

- Genetic theories (of drug use) = rely on chromosomal differences in the population which influence the predisposition to take or abuse psychoactive substances
- While many highlight the way that alcoholism runs in families, family history implicates plenty of social mechanisms as well.
- More importantly, this research has found particular gene sequences are much more likely to be found among alcoholics, than non-alcoholics.
- Gene or combination of genes are argued to influence particular biological mechanisms relevant to substance abuse:
 - Being able to achieve a certain level of intoxication
 - Lowering/not lowering anxiety levels when under influence
 - Capacity to metabolize chemical substances



Model of Psychological Addiction

- Beginning in the 1970s and into the 1980s, the classic model of addiction was replaced as the dominant paradigm for addiction. In its place the Dependence/Reinforcement Model predominated.
- For this model, positive reinforcement is the driving force in generating continued, compulsive, abusive drug use
- A drug does not have to be physically addicting to produce dependency in users (Note: Plus, avoidance of withdrawal can be thought of as a negative reinforcement)
- Studied rats who were provided cocaine-laced water. Did not suffer obvious physical withdrawal, when taken away, but if provided again, rats would compulsively use until it killed them (so, did not die from withdrawal, but from excessive use).

The Reinforcement/Dependence Model

- Consequently, **psychological dependence**, instead of “physical addiction,” became the dominant model. Theory was usually rooted in a behavioral psychology of reinforcement and conditioning.
- Researchers argued that cocaine ‘sensual appeal,’ physiologically and psychologically, meant that cocaine, not opiate, addiction was the prototypical example.
- Concerns about the exceptional potency of cocaine addiction became mirrored in societal concerns regarding cocaine, especially crack cocaine, in the 1980s. (Again, highlighting links between theory and public policy.)

Psychological Theories

- Psychological theories (of drug use) = based either on reinforcement, whether positive or negative, or personality type
 - Reinforcement theories suggest individuals continue drug use because they have a past history of being rewarded for doing them (behavioral psych)
 - Personality theories suggest individuals have a type of personality that compels them to use/abuse drugs (cognitive psych)

Behavior Psychology

1. Reinforcement theories (of drug use) = based on the idea that drug use is caused by the reinforcing effects of psychoactive drugs

- Positive reinforcement = motivation to continue using drug because of positive sensations
- Negative reinforcement = motivation to continue using drug to avoid withdrawal symptoms

Cognitive (Personality) Psychology

1. Inadequate personality theories (of drug use) = based on the notion that young people who lack self-esteem, are unable to cope with life, who are failures, turn to drugs to drown out the feelings of failure

- Drugs use masks some of life's problems
- The more inadequate the personality, the greater the likelihood of becoming highly involved in drug use
- For the weak, drug use is a kind of crutch
- Drug use also viewed as defense mechanism

Inadequate Personality

Examples: Self esteem and Self-derogation theory

- Drug use/abuse, like deviant/criminal behavior, are responses to low self-esteem and/or self-rejecting attitudes
- For some, normatively approved activities and group memberships are sources of painful experiences; deviant/disapproved activities and memberships act as effective sources of self-enhancement; drug use provides this type of deviant activity and group membership

Problem-Behavior Proneness

Problem-behavior proneness theory (of drug use) = argues that drug use is simply one specific manifestation of a wide range of problematic behaviors, such as early sex, juvenile delinquency, conflict with alienation from parents, and impulsivity

- Drug users more unconventional and risk taking than nonusers
- The more unconventional the youth, the greater the likelihood he/she will use drugs; the more unconventional, the more serious the drug involvement
- In contrast to inadequate personality, unconventionality has pluses as well as minuses. For instance, greater creativity, entrepreneurialism, and innovation are all associated with certain levels of unconventionality

Problem-Behavior Proneness (cont'd)

- Sociologists would suggest shifting the language to “Unconventional Personality,” as opposed to Problem-Behavior Proneness
 - This highlights that there are other elements associated with unconventionality (e.g. entrepreneurship, creativity, fearlessness/willingness to transgress boundaries) which might have positive valences. Thus, the same personality trait that makes someone a powerful artist, could also predispose them to using drugs. Be aware of how values are implicated in language.

Sociological Theories

Sociological theories (of drug use) = make use of broader, structural, cultural, or institutional factors and variables

1. Anomie Theory
2. Social Control and Self-Control Theory
3. Social Learning and Subculture Theory
4. Selective Interaction/Socialization Theory
5. Conflict Theory

Theories of Deviance

1. Anomie theory = argues that nonconforming behavior is the product of a malintegrated society whose culture encourages material achievement but whose social structure and economic structure denies that same achievement to most members, thus leading to strain, which results in deviant adaptations

- Merton's (1938- adaption from Durkheim)



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Social Control and Self-Control Theory

Social control theory = argues that violations of the norms, particularly juvenile delinquency, take place to the extent that bonds to conventional others, conventional beliefs, and conventional activities are weak or absent

- 'Stake in conformity'- When people have jobs, homes, important family relationships, they will avoid deviant behavior such as drug use; On the other hand, people who lack jobs, homes, strong family bonds, then they have 'less to lose.' Put simply, deviance results from a lack of social control.
- Self-control theory = explanation that argues that deviant, criminal, and delinquent behavior – including recreational drug use – are caused by low self-control which, in turn, is caused by poor, inadequate parenting
 - Rather than highlighting the role that emergent adult ties play in social control, this emphasizes how a lack of proper family ties in childhood means individuals never learn impulse control, which is required to develop those adult ties.
- Both theories assume people 'will use' unless sources of control develop to limit use.

Social Learning and Subculture Theory

- Social learning theory = theory of deviance which argues that deviant, criminal, and delinquent behavior are learned in a more-or-less straightforward manner from those you interact with
 - Consider: How would you learn to be an IV drug user? (Without interacting with a user, would you have the first idea how to go about 'shooting up'?)
- Subcultural theories = explanations of use, abuse, or addiction based on the notion that group-based norms, values, beliefs, and behavior influence drug taking
 - Not only do we learn from individuals, but groups socialize us into values, beliefs and behaviors. As a result of exposure to social circles whose members define engaging in nonnormative activity in positive terms, we adopt congruent values, beliefs, and behaviors.



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Selective Interaction/ Socialization Theory

- Selective interaction = drug users do not randomly fall into social circles of users; attracted to those they are compatible with
- Selective interaction/socialization theory = argues that young people use recreational drugs because, first, they gravitate toward social circles whose members are compatible in a range of ways, drug use included, and second, because these circles further socialize them into the desirability of using drugs; the theory further argues that different factors are more influential at different stages of the young person's life, that is, as he or she moves from younger to older adolescence into young adulthood
- Selective interaction highlights an attempt to wed psychological theories of personality and individual level preference with social theories of subculture and learning.

Conflict Theory

- Conflict theory = argues that social behavior is the outcome of differences among groups and categories in the population in power, wealth and resources; drug abuse and drug selling tends to be more entrenched in poorer, more disorganized neighborhoods because viable economic options for residents are limited and community members find it difficult to combat the power of drug dealers
- Represents a macro level explanation of drug use

Module 5: Drugs & Media

Key Questions

- Are the news media biased?
- What are the four theories that explain media bias?
- How is this the social construction of a social problem?
- What is sensationalism in the media when it comes to drugs?
- What is the history of drugs in the media?
- Do the media glorify drugs in today's society?

Are the News Media Biased? #1

Bias can have at least two meanings

- **Factual bias:** Making factually and empirically false claims or assertions to justify a particular moral, ideological, or political position
- **Selection bias:** Focusing on the particular facts that support a certain slant or position and ignoring those that challenge or undermine it

All news media are equally concerned about issues of factual accuracy

- Higher the prestige of a particular media institution, the more professional embarrassment factually false stories cause

Are the News Media Biased? #2

What editors and publishers consider factually wrong assertions are nearly always specific, concrete facts

Selection bias: The kind of bias is less a question of factual correctness than of the slant or focus of stories based on factually correct specific facts

- In this respect, the media are biased
- They tend to present a particular angle or point of view on the events of the day

The Four Theories that Explain Media Bias

- Ruling-elite theory
- Money machine theory
- Grassroots theory
- Professional subculture theory

The Ruling-Elite Theory

- Argues that the media consciously and purposely serve the interests of the ruling elite
- Media distorts news in a way that favors the ruling class and helps maintain the status quo
- Ideology is the central factor at work, not profits for the press

Money Machine Theory

- Argues that owners of newspapers and television stations are interested in the bottom line, not political indoctrination
- News coverage is unduly influenced by the financial bean counters
- Delivering a profit has become the guiding principle of news organizations, leading to triviality, sensationalism, bias, and irrelevancy

Grassroots Theory

- The slant and content of the mass media are a product of the interests and beliefs of the majority of the population
- Not so different than money machine theory, because what appeals to masses is likely to make a profit
- If the media can be said to have a bias, it is the bias of their audiences

Professional Subculture Theory

The slant and content of the mass media are a product of the norms and ethics of journalists, which are:

- To verify a story with two or more sources
- To always keep in mind the cardinal rule of journalism: Accuracy
- Tell the story in human terms
- To shape the story with a specific audience in mind

The Social Construction of a Social Problem

Drug use and abuse have an objective and a subjective side

- The subjective side relates to the feelings, attitudes, and beliefs of the public
- The objective side deals with:
 - What drugs actually do to humans who use them
 - How widely and frequently they are used
 - What kind of impact they have on the society

The public's estimates of the objective harm of specific conditions, behaviors, and issues are extremely faulty and are influenced by a wide range of extraneous factors

Sensationalism in the Media

Mass media presents stories in an exaggerated, biased, and lurid fashion

- Designed to stimulate interest and excitement in the media-consuming public

Most of what sociologists and criminologists know about drug use is not newsworthy

- Nor is the way most sociologists and criminologists approach and study drugs especially interesting to the public

Brief History of Drugs in the Media

How has the media portrayal of certain drugs changed over the years?

And how have these media portrayals influenced policies and legislation?

EXAMPLE 1: Marijuana in the 1930s

- Marijuana was believed to be not just dangerous but a menace
- By 1960s, anti-marijuana propagandists and the media dropped the violence theme
- Today, most agree that marijuana does not cause or induce users to violence

EXAMPLE 2: LSD IN THE 1960s

- There was a suggested link between LSD and birth defects such as mental illness
- Media attention to LSD triggered, or at least preceded, criminal legislation
- Federal Drug Abuse Control Amendments, which penalized the manufacture and sale of hallucinogens including LSD, was passed in 1965 and became effective in 1966

EXAMPLE 3: PCP (Phencyclidine) in the 1970s

- There was a suggested link between PCP and bizarre behavior such as self-mutilation
- Media accounts of PCP were extremely narrowly focused
- The media sensationalized PCP and exaggerated the most bizarre effects of the drug

EXAMPLE 4: Crack in the 1980s

- Was linked with drug gangs and murder of innocent middle-class bystanders
- Media speculations of crack baby syndrome existed
- Drug bills and drug legislation followed in the wake of the 1980s media panic over crack abuse

EXAMPLE 5: Methamphetamine in the Late 1980s to the 2000s

- Methamphetamine was the drug of choice for a “new generation”
- Law enforcement was put on notice
- The media continued to report the meth epidemic well into the 2000s
- How the methamphetamine story was handled moved from exaggeration and sensationalism to skepticism and accuracy

EXAMPLE 6: The Media Cover the Opiate Epidemic

- During the first years of the twenty-first century, the number of users and abusers who died from an overdose of one or more of the opiates began to rise
- While the earlier era abusers were blamed for a moral failing, the stories on the contemporary crisis stress the medical features of the problem
- The stories in the media about the current opiate use stand apart from earlier coverage by the link forged with the legal drug industry in causing the explosion of both use and deaths

The 21st Century: Do the Media Glorify Drugs? #1

It is clear that some depictions of drug users and sellers are positive

Wikipedia lists over a thousand films in which illicit substance use and/or sales make a significant appearance

- In many, possibly most of them, the drug users are depicted in mostly positive ways

Though drug users are not usually glorified in films, they are not cast as unambiguous villains

The 21st Century: Do the Media Glorify Drugs? #2

- Narcotics addicts are most often depicted as living sordid, ignominious, and ultimately tragic lives
- Given their greater popularity in everyday life, cigarettes and alcohol very often appear as a component of the everyday lives of movie characters, and in a largely positive light

Module 6: Alcohol Use in the United States



What We'll Cover

1. Acute Effects of Alcohol
2. Prevalence of Drinking
3. Alcohol Use Disorder in the United States
4. Alcohol-Related Emergencies and Deaths
5. Underage Drinking in the United States
6. Binge Drinking

Acute Effects of Alcohol

- Alcohol is a depressant; most widely used sedative
 - Depresses, slows down, retards many functions and activities of organs in the body; if dose is too high, organs may shut down
 - Disorganizes/impairs ability of the brain to process and use information
 - In most people, produces mild euphoria & reduces anxiety, fear, and tension; also reduces inhibitions/increases willingness to take risks

Acute Effects of Alcohol (2)

- Potency (quantity required to produce effect) of alcoholic beverages measured by % of alcohol
 - Beer = 4-5% alcohol
 - Wine = 10-13% alcohol
 - Scotch, vodka, etc. = 40-50% alcohol
- Rule of equivalency = the principle that the effects of alcohol are related solely and exclusively to the total volume of absolute alcohol in the body
 - Denies that different drinks – independent of alcohol content – have different levels of potency

Blood Alcohol Concentration

- Blood alcohol concentration (BAC) = the %, by volume, that alcohol comprises of the total content of blood in the body; 0.08% commonly defined as legal intoxication in states throughout U.S. (0.02% for minors)
 - The effects of alcohol, to a large degree, are dose related
 - Effects of alcohol influenced or mitigated by: size of drinker, gender, presence of food/water in the stomach

Prevalence of Drinking

- 85.6% of people ages 18 and older reported they drank alcohol at some point in their **lifetime**.
- In the past year 69.5% reported that they drank in the **past year**.
- 54% reported that they drank in the past **month**.

- (Source: Alcohol Facts and Statistics, based on 2019 National Survey on Drug Use and Health-**required reading**)



Alcohol Use Disorder (AUD) in the United States

- 14.5 million people ages **12 and older** had AUD (9 million men; 5.5 million women).
- 414,000 adolescents ages 12 to 17 had AUD (163,000 males; 251,000 females). Why do females outnumber males in this age category?
- (Source: Alcohol Facts and Statistics, based on 2019 National Survey on Drug Use and Health-**required reading**)

Treatment of AUD in the United States

- 7.2% of people ages 12 and older who had AUD received treatment in the past year.
- 6.4% of adolescents ages 12 to 17 who had AUD received treatment in the past year.
- People with AUD were more likely to seek care from a primary care physician for an alcohol-related medical problem, rather than specifically for drinking too much alcohol.
- (Source: Alcohol Facts and Statistics, based on 2019 National Survey on Drug Use and Health-**required reading**)

Alcohol-Related Emergencies and Deaths in the United States

- Alcohol contributes to about 18.5% of Emergency Departments (ED) visits.
- An estimated 95,000 people die from alcohol-related causes annually.
- Alcohol is the third-leading preventable cause of death in the United States (behind tobacco and poor diet).
- (Source: Alcohol Facts and Statistics, based on 2019 National Survey on Drug Use and Health-**required reading**)

Alcohol-Attributable Deaths

- Between 2011 and 2015, the leading causes of alcohol-attributable deaths due to chronic conditions in the United States were alcohol-associated liver disease, heart disease and stroke, unspecified liver cirrhosis, upper aerodigestive tract cancers, supraventricular cardiac dysrhythmia, AUD, breast cancer, and hypertension.
- (Source: Alcohol Facts and Statistics, based on 2019 National Survey on Drug Use and Health-**required reading**)

Economic Burden

- In 2010, alcohol misuse cost the United States \$249 billion
- In 2016, 3 million deaths, or 5.3% of all global deaths were attributable to alcohol consumption.

- (Source: Alcohol Facts and Statistics, based on 2019 National Survey on Drug Use and Health-**required reading**)

Underage Drinking in the United States

- 39.7% of 12- to 20-year-olds reported that they had at least 1 drink in their lives.
- About 7.0 million people ages 12 to 20 reported drinking alcohol in the past month.
- (Source: Alcohol Facts and Statistics, based on 2019 National Survey on Drug Use and Health-**required reading**)

Decline in Underage Drinking

- NSDUH findings have demonstrated a decline in underage drinking. From 2002 to 2019, the prevalence of past-30-day alcohol use decreased 41.1 percent for 16- to 17-year-olds, 54.7 percent for 14- to 15-year-olds, and 61.9 percent for 12- to 13-year-olds.
- (Source: Alcohol Facts and Statistics, based on 2019 National Survey on Drug Use and Health-**required reading**)

Consequences of Underage Alcohol Use

- Research indicates that alcohol use during the teenage years can interfere with normal adolescent brain development and increase the risk of developing AUD. In addition, underage drinking contributes to a range of acute consequences, such as injuries, sexual assaults, alcohol overdoses, and deaths—including those from motor vehicle crashes.
- (Source: Alcohol Facts and Statistics, based on 2019 National Survey on Drug Use and Health-**required reading**)



Alcohol Consumption Today

- Since 1980, the use of alcohol has declined on a year-to-year basis; now stands at slightly above 2 gallons of absolute alcohol per year per teenager or adult
- We have also witnessed a decrease in alcohol-related highway fatalities among young drivers (16- to 20-year olds)
 - Link to nationwide prohibition on sale of alcohol to persons under the age of 21?
- What about binge drinking?

Binge Drinking

- Approximately 825,000 people ages 12 to 20 reported binge drinking in the past month. This represents 11.1% of people in this age group (10 % of males ages 12 to 20 and 11.8% of females ages 12 to 20).
- According to the 2020 National Survey on Drug Use and Health (NSDUH), binge drinking for males was defined as drinking five or more drinks on the same occasion on at least 1 day in the past 30 days.
- According to the 2020 National Survey on Drug Use and Health (NSDUH), binge drinking for females was defined as drinking 4 or more drinks on the same occasion on at least 1 day in the past 30 days.



Heavy Alcohol Use

- In the NSDUH survey, **heavy** alcohol use is defined as binge drinking on five or more days in the past 30 days based on the thresholds for binge drinking established for males and females

- Source: 2020 National Survey on Drug Use and Health-**required reading**



What is the national age 21 drinking law?

- The National Minimum Drinking Age Act of 1984 required all states to raise their minimum purchase and public possession of alcohol age to 21. States that did not comply faced a reduction in highway funds under the Federal Highway Aid Act. The U.S. Department of Transportation has determined that all states are in compliance with this act.

Is Drinking by Minors Prohibited?

- The national law specifically requires states to prohibit purchase and public possession of alcoholic beverages. It does not require prohibition of persons under 21 (also called youth or minors) from drinking alcoholic beverages.

Exceptions to age 21 Drinking

- The term “public possession” is strictly defined and does not apply to possession for the following.
- An established religious purpose, when accompanied by a parent, spouse, or legal guardian age 21 or older;
- Medical purposes when prescribed or administered by a licensed physician, pharmacist, dentist, nurse, hospital, or medical institution;
- In private clubs or establishments; and
- In the course of lawful employment by a duly licensed manufacturer, wholesaler or retailer



Who Drinks? Who Doesn't?

- Drinking positively related to social class or socioeconomic status (SES) – the higher the income, education, and occupational prestige, the greater the likelihood that someone will drink
 - However, upper-SES persons more likely to drink moderately than lower-SES persons
- Men more likely to drink than women – men also drink at greater volume
- Young adults under the age of 35 most likely to drink – likelihood of drinking declines with age (slowly)

Module 7: Tobacco and Vaping



What We'll Cover

- History of Tobacco
- Vaping: Nicotine and Marijuana
- Cigarette Trends and Use
- Defining Nicotine Addiction
- Addiction in Tobacco Litigation, 1990 to 2003

Cigarette Smoking

- Cigarette smoking among young adults significantly declined over the past five years (2015-2020), a continuation of longer-term declines and reaching historic lows in 2020.)

- Source: Monitoring the Future 2020, Volume 2

Vaping: Marijuana (Annual Prevalence)

- Annual prevalence of vaping marijuana was 11% in 2017, 15% in 2018, 22% in 2019, and 20% in 2020 among 19-30 year olds overall, showing significant annual increases through 2019, and a nonsignificant 1.5 percentage point decline in 2020 (Table 5-2, page 105).
- Source: Monitoring the Future 2020, Volume 2

2020 Levels of Smoking at Historic Lows

- Between 2015 and 2020, annual prevalence declined a significant 4.3 percentage points to 21% in 2020 (Table 5-2), 30-day prevalence declined a significant 7.0 percentage points to 9.5% in 2020 (Table 5-3), daily smoking declined a significant 4.6 percentage points to 5.3% in 2020 (Table 5-4), and smoking half-pack-a-day or more declined a significant 3.2 percentage points to 2.8% in 2020 (Table 5-4, p. 108).
- On all of these measures of smoking, the 2020 levels were at historic lows.

- Source: Monitoring the Future 2020, Volume 2



Vaping

- In 2018, vaping among 10th and 12th graders was the largest jump ever seen in any substance tracked by Monitoring the Future Study for the past 43 years.”
- Source: Associated Press Video (Adolescents and Vaping)

Vaping Marijuana (30 Day Prevalence)

- Thirty-day prevalence of vaping marijuana was 6.1% in 2017, 8.6% in 2018, 13% in 2019, and 11% in 2020 among 19-30 year olds overall, showing a significant one-year increase in 2018 and 2019, and a significant 2.2 percentage point decrease in 2020 (Table 5-3, page 105).
- Source: Monitoring the Future 2020, Volume 2

Vaping: Nicotine (Annual Prevalence)

- Annual prevalence of vaping nicotine was 13% in 2017, 17% in 2018, 24% in 2019, and 22% in 2020 among 19-30 year olds, showing a significant one-year increase in both 2018 and 2019 but a halt to the increases in 2020 (Table 5-2, p. 109).
- Source: Monitoring the Future 2020, Volume 2

Vaping Nicotine (30 Day Prevalence)

- Thirty-day prevalence of vaping nicotine was 6.2% in 2017, 9.9% in 2018, 14% in 2019, and 14% in 2020 among 19-30 year olds, showing significant one-year increases in 2018 and 2019 (Table 5-3, p. 109).

Debating Tobacco Addiction

- Is tobacco addictive?
- What is meant by “addictive?”
- Who defines definition of addictions?
- What constitutes addiction and dependence?

Who Defines Tobacco, Nicotine, Addiction?

- United States Surgeon General's Advisory Committee
- Official Committees of the World Health Organization

Defining Addiction

- In Britain, a major policy report for the Royal College of Physicians referred to tobacco addiction in 1962.
- The U.S. Surgeon general described smoking as “habituation” rather than an addiction in 1964.
- The WHO’s International Classification of Diseases first included tobacco dependence as a diagnostic category in 1977, and the American Psychiatric Association followed suit in 1980.
- Source: American Journal of Public Health, Oct. 2008, vol. 98, No. 10: Experts Debating Alcohol Addiction

Surgeon General's Advisory Committee (SGAC)

- Described tobacco as causing “habituation” rather than “addiction.”
- SGAC used definitions from WHO published in 1957, in which “drug addiction” involved intoxication, an overpowering desire to continue taking the drug and to obtain it by any means. . . “(p.1795).
- Characterized the urge to use a drug as “a desire” but not “not a compulsion”.
- The WHO revised its definition in 1964, dropping the habituation-addiction split and replacing it with the single term “dependence” (p. 1795)
- Source: American Journal of Public Health, Oct. 2008, vol. 98, No. 10: Experts Debating Alcohol Addiction



Change of Definitions

- In 1988 the Surgeon General adopted definitions from the American Psychiatric Association, the National Institute on Drug Abuse, and the 1964 WHO revision.
- The 1988 surgeon general's report used the terms “addiction” and
- “dependence” synonymously.

Three Conclusions of 1988 Surgeon General's Report

- Nicotine was addicting
 - Nicotine was the drug in tobacco that caused addiction
 - The pharmacological and behavioral processes that determined tobacco addiction were similar to those for heroin and cocaine.
-
- Source: American Journal of Public Health, Oct. 2008, vol. 98, No. 10: Experts Debating Alcohol Addiction

Addiction In Tobacco Litigation, 1990 to 2003

- Expert witnesses explain scientific evidence on tobacco and its addiction potential.
- Experts for the tobacco industry, using early definitions of “habituation” and “addiction”, argued against definitions that characterized tobacco or nicotine as addictive. They claimed that tobacco was merely a habit that could be broken, equivalent to any other pleasurable activity.
- Experts for the plaintiffs, using definition from 1988 Surgeon General’s Report, claimed that tobacco produced dependence or addiction. Source: American Journal of Public Health, Oct. 2008, vol. 98, No. 10: Experts Debating Alcohol Addiction



Experts Agree

- After October 1999, when most companies had declared tobacco to be addictive, defense experts (hired by tobacco companies) changed their views in line with their employers.

Module 8: Misusing Legal Drugs

Over-the-Counter (OTC), Prescription, and Herbal Drugs



Key Questions

- What are legal drugs (prescriptions, over-the-counter and herbals drugs)?
- How can you misuse over-the-counter and prescriptions drugs?
- What is the federal government's role in monitoring (e.g., proper labeling)?
- Why is proper patient-provider communication important?

Prescription and OTC Drugs #1

- **Prescription** drugs are available only by recommendation of a licensed health professional, such as a physician.
- **Nonprescription** (over-the-counter, or OTC) drugs are available on request and generally do not require approval by a health professional.

Prescription and OTC Drugs #2

- Prescription and OTC drugs have been viewed differently by the public since the classifications were established by the Durham-Humphrey Amendment of 1951.
- In general, the public views OTC drugs as less effective, safe, and rarely abused and prescription drugs as more potent and potentially dangerous. However, these distinctions are not always accurate.

Over-the-Counter Drugs

OTC Drugs: Interesting Facts

- Each year, people in the United States spend ~\$30 to \$40 billion on OTC drugs.
- More than 100,000 different OTC products are available on the market.
- OTC expenditures comprise ~10% of the annual drug purchases in the United States.

OTC Drugs and Self-Care

- Many of the major health problems in the United States can be treated with OTC medications.
- If done correctly, self-care with OTC medications can provide significant relief from minor, self-limiting health problems at minimal cost.

Types of OTC Drugs #1

- Internal analgesics
 - Salicylates
 - Acetaminophen
 - Ibuprofen
 - Ibuprofen-like
- Therapeutic considerations
 - Analgesic actions
 - Anti-inflammatory effects
 - Antipyretic effects
 - Side effects

Types of OTC Drugs #2

- Cold, allergy, and cough remedies
 - Decongestants
 - Antitussives
 - Expectorants
- Sleep aids
 - Antihistamines
 - Melatonin
- Stimulants
 - Stay-awake or energy-promoting

Types of OTC Drugs #3

- Gastrointestinal medication
 - Antacids and anti-heartburn medication
- Diet aids
- Skin products
 - Acne medications
 - Sun products
- Skin first-aid products
- OTC herbal products

Misusing OTC Drugs #1

- OTC products generally have a greater margin of safety than their prescription counterparts, but issues of abuse need to be considered.
- Physical dependence.
- Psychological dependence.

Misusing OTC Drugs #2

- Nonprescription products that can be quite habit-forming: decongestants, laxatives, antihistamines, sleep aids, and antacids.
- OTC drugs are more likely to be abused by members of the general public who inadvertently become dependent due to excessive self-medication than by hardcore drug addicts.

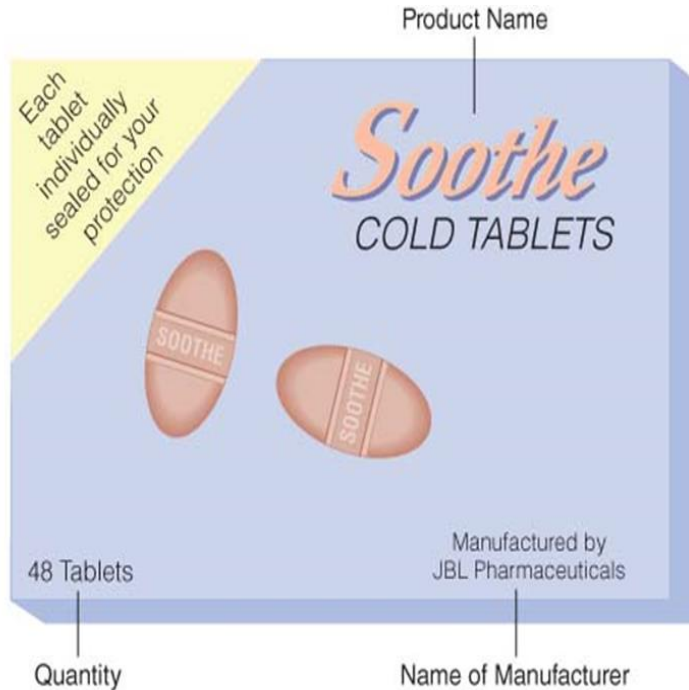
“Switching” Policy of the FDA

- The FDA (The Food & Drug Administration which is part of the US government) is attempting to make more drugs available to the general public by switching some frequently used and safe prescription medications to OTC status.
- There have been approximately 100 active ingredients switched, leading to hundreds of new effective OTC drug products.

OTC Labels

- Required label information includes:
 - Approved uses of the product
 - Detailed instructions on safe and effective use
 - Cautions or warnings to those at greatest risk when taking the medication

OTC Label. Certain information must appear on the labels of an OTC medicinal product.



List of Active Ingredients

Drug Facts	
Active ingredient (in each tablet) Chlorpheniramine maleate 2 mg	Purpose Antihistamine
Uses: temporarily relieves these symptoms due to hay fever or other upper respiratory allergies: • sneezing • runny nose • itchy, watery eyes • itchy throat	
Warnings: Ask a doctor before use if you have: • glaucoma • a breathing problem such as emphysema or chronic bronchitis • trouble urinating due to an enlarged prostate gland Ask a doctor or pharmacist before use if you are taking tranquilizers or sedatives.	
When using this product: • you may get drowsy • avoid alcoholic drinks • alcohol, sedatives, and tranquilizers may increase drowsiness • be careful when driving a motor vehicle or operating machinery • excitability may occur, especially in children	
If pregnant or breast-feeding, ask a health professional before use. Keep out of reach of children. In case of overdose, get medical help or contact a Poison Control Center right away.	
Directions	
adults and children 12 years and over	take 2 tablets every 4 to 6 hours; not more than 12 tablets in 24 hours
children 6 years to under 12 years	take 1 tablet every 4 to 6 hours; not more than 6 tablets in 24 hours
children under 6 years	ask a doctor
Other Information: • store at 20-25C (68-77F) • protect from excessive moisture	
Inactive ingredients: D&C yellow no. 10, lactose, magnesium stearate, microcrystalline cellulose, pregelatinized starch	

Directions Warnings Indications for Use

Rules for Proper OTC Drug Use

- Make sure your self diagnosis is accurate.
- Always know what you are taking.
- Know the effects.
- Read and heed the warnings and cautions.
- Don't use anything for more than 1 to 2 weeks.
- Be particularly cautious if also taking prescription drugs or herbal products.
- If you have questions, ask a pharmacist.
- If you don't need it, don't use it!

Prescription Drugs

Prescription Drugs #1

- There are currently more than 10,000 prescription products sold in the United States, representing:
 - Approximately 1500 different drugs
 - With 20 to 50 new medications approved each year by the FDA
 - There are more than 70 deaths each day from prescription drugs

Prescription Drugs #2

- According to the Durham-Humphrey Amendment of 1951, drugs are controlled with prescription if they are:
 - Habit-forming
 - Not safe for self-medication
 - Intended to treat ailments that require the supervision of a health professional
 - New and without an established safe track record

Generic Versus Proprietary Drugs

- **Generic:** The official, nonpatented, nonproprietary name of a drug. The term *generic* is used by the public to refer to the common name of a drug that is not subject to trademark rights.
- **Proprietary:** A brand or trademark name that is registered with the U.S. Patent Office. Proprietary denoted medications are marketed under specific brand names, such as Valium.

Common Categories of Prescription Drugs #1

- Analgesics
 - Nonsteroidal anti-inflammatory (NSAIDS)
 - Narcotic analgesics
- Antibiotics
 - Antibacterials
- Antidepressants
- Antidiabetic drugs
- Antiulcer drugs
- Bronchodilators

Common Categories of Prescription Drugs #2

- Cardiovascular drugs
 - Antihypertensive agents
 - Antianginal agents
 - Drugs to treat congestive heart failure
 - Cholesterol and lipid-lowering drugs
- Hormone-related drugs
- Sedative-hypnotic agents
- Stimulants
- Drugs to treat HIV

Doctor-Patient Communication

- When a physician prescribes a drug, a patient should insist on answers to the following questions:
 - What is being treated?
 - What is the desired outcome?
 - What are the possible side effects of the drug?
 - How should the drug be taken to minimize problems and maximize benefits?
- In order to maximize benefit and minimize risk, there must be proper doctor–patient communication.

Common Principles of Drug Misuse

- Patients should ask the following:
 - Why am I taking this drug?
 - How should I be taking this drug?
 - What are the active ingredients?
 - What are the most likely side effects?
 - How long should I be taking this drug?

So, what exactly is prescription drug misuse?

- Taking a medication that was not prescribed to you
- Purposely taking the wrong dosage of a prescribed medication
- Taking a prescribed medication for something other than its intended use

What are the most common misused prescription drugs?

- Opiates (Painkillers)
 - OxContin
 - Percocet
 - Vicodin
- Sedatives and Tranquilizers
 - Ativan
 - Valium
 - Xanax
- Stimulants
 - Adderall
 - Ritalin
 - Dexedrine
- OTCs
 - Products containing dextromethorphan (a cough suppressant)

Prescription Drug Misuse #1

- Overall cost of prescription painkiller abuse is \$70 billion per year.
- Most prescription deaths in the United States are from prescription painkillers.
- There has been a 4-fold increase in incidents of prescription abuse in the past 10 years.
- 70% of those who abuse prescription drugs get them from friends and relations.
- Two-thirds of college students have been offered prescription stimulants as performance enhancers.

Prescription Drug Misuse #2

- Illicit use of prescription drugs may be prompted by several reasons, such as:
 - To relieve withdrawal caused by drug habits
 - To treat infections caused by drug abuse
 - To provide a source of fresh, clean needles for injecting drugs of abuse
 - To prolong high caused by other drugs of abuse

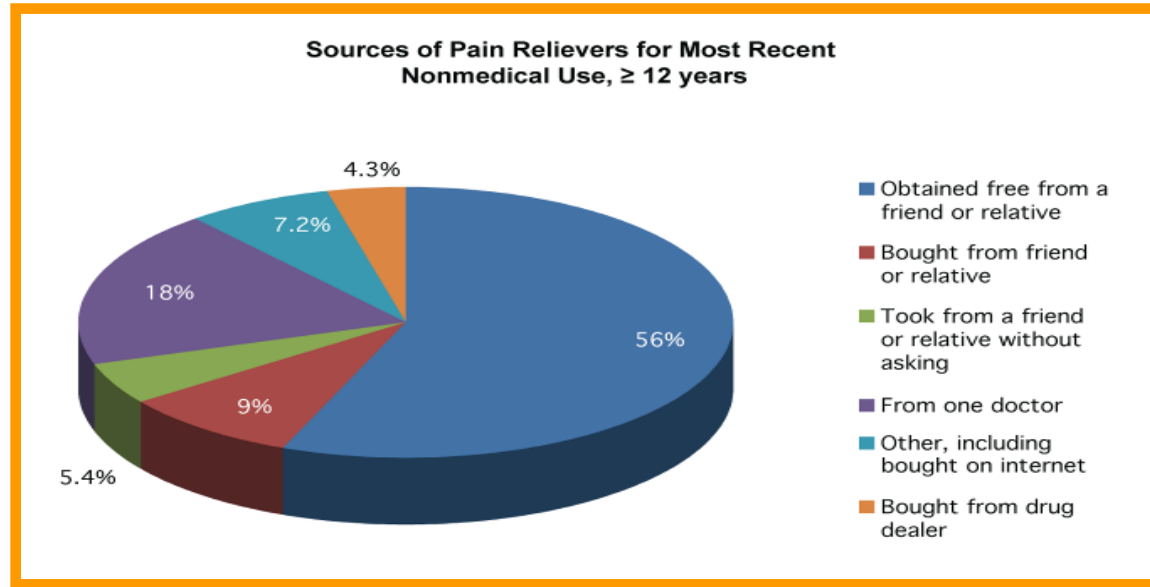
Why should we care?

- **Four of the top five drugs abused by 12th graders** are prescription or over-the-counter medications.
- **20%** of teens are abusing prescription drugs.
- In Ohio, the **number one cause** of accidental death is drug use. **95%** of the drugs used are prescription drugs.
- **33%** of teens feel pressured to abuse prescription drugs.

Why do people misuse prescription drugs?

- Do not see a great risk in trying prescription drugs without a doctor's prescription (especially painkillers)
- They believe prescription drugs are safer than street drugs and are not addictive
- Prescription drugs are much more difficult to detect than street drugs
- Prescription drugs are much easier to attain than street drugs

Where do they get them?



How to Deal With Unused Prescription Drugs

- Do not flush extra medications, as they may contaminate the water.
- Store in a secure place so they can't be stolen.
- Do not leave labels with your personal information on prescription drugs you are disposing.
- Place drugs in bag with either coffee or cat litter before throwing it away.
- Drop medications off at a secure drop-off box such as that in some pharmacies.

Module 9:

Illicit Drugs – Part 1

Heroin and the War on Drugs

What We'll Cover

- Description of Heroin
- Prevalence of Heroin Use
- History of Rockefeller Drug Laws
- Federal Sentencing Guidelines for Heroin
- Heroin Overdose Data

Description of Heroin

- **"Heroin is an opiate drug that is synthesized from morphine, a naturally occurring substance extracted from the seed pod of the Asian opium poppy plant. Heroin usually appears as a white or brown powder or as a black sticky substance, known as 'black tar heroin.'"**
- *National Institute on Drug Abuse, [DrugFacts: Heroin](#) (Rockville, MD: US Department of Health and Human Services, Revised March 2010), last accessed Jan. 12, 2013.*

Prevalence of Heroin Use

- **Among people aged 12 or older, the percentage who were past year heroin users increased from 0.2 percent (or 404,000 people) in 2002 to 0.3 percent (or 745,000 people) in 2019 (Figure 14 and 2019 DT 7.2). The percentage of people in 2019 who were past year heroin users was higher than the percentages in most years from 2002 to 2008, but it was similar to the percentages in 2009 to 2018.**

- **Source: Drug Policy Facts: Required reading**

History of Rockefeller Drug Laws

Punitive Approach

- In May of 1973, New York's Governor Nelson Rockefeller pushed through the state legislature a set of stringent anti-drug laws. Among the most severe in the nation, the purpose of these laws was and is to deter citizens from using or selling drugs and to punish and isolate from society those who were not deterred.
- It was thought that rehabilitative efforts had failed; that the epidemic of drug abuse could be quelled only by the threat of inflexible, and therefore certain, exceptionally severe punishment.
- Source: Rockefeller Drug Laws Information Sheet

Establish Mandatory Sentences

- The new drug laws, which have since become known as the "Rockefeller Drug Laws" established mandatory prison sentences for the unlawful possession and sale of controlled substances keyed to the weight of the drug involved.
- Source: Rockefeller Drug Laws Information Sheet

Did the Punitive Approach Work?

- In 1977, despite the expenditure of \$76 million and the appointment of 49 additional judges to handle cases under the new law, it was described as a dismal failure.
- The percentage of the prison population incarcerated for drug offenses has been increasing since 1973, the year the Rockefeller Drug Laws were enacted, with particularly sharp increases during the 1980's.
- Source: Rockefeller Drug Laws Information Sheet

Increase In Drug Felonies

- These mandatory minimum sentences for drug felonies increased the percentage of convicted drug offenders who receive prison sentences. As a consequence, the NYS prison population changed from one in which 9% were serving time for drug felonies (1980) to 32.2% (1997).
- Source: Rockefeller Drug Laws Information Sheet

Possible federal sentences for heroin possession include:

- **Amount: 1 kilogram or more of a mixture or substance containing a detectable amount of heroin.**
Sentence: Not less than 10 years or more than life. No person sentenced under this subparagraph shall be eligible for parole during the term of imprisonment.
- [*Title 21 United States Code \(USC\) Controlled Substances Act*](#), last accessed July 9, 2021.

Possible federal sentences for heroin possession include:

- **Amount: 100 grams or more of a mixture or substance containing a detectable amount of heroin.**
Sentence: Not less than 5 years and not more than 40 years. No person sentenced under this subparagraph shall be eligible for parole during the term of imprisonment.
- [*Title 21 United States Code \(USC\) Controlled Substances Act*](#), last accessed July 9, 2021.

Heroin Overdose Data

- In 2019, heroin-involved overdose death rates decreased over 6% from 2018 to 2019. However, more than 14,000 people died from a drug overdose involving heroin in the United States, a rate of more than four deaths for every 100,000 Americans.

- Centers for Disease Control and Prevention, Data Overview-Heroin.

Opioid Deaths

- The number of heroin-involved overdose deaths was more than seven times higher in 2019 than in 1999. Nearly a third of all opioid deaths involved heroin.¹

- Centers for Disease Control and Prevention, Data Overview-Heroin.

TEDS Heroin Admissions

- **Heroin was reported as the primary substance of abuse for 26 percent of TEDS admissions aged 12 and older in 2015**

- Source: Drug Policy Facts: **Required reading-Heroin Chapter**

Race and Heroin Admissions

- **Sixty-seven percent of primary heroin admissions were non-Hispanic White (41 percent were males and 26 percent were females). Non-Hispanic Blacks made up 14 percent (9 percent were males and 5 percent were females). Admissions of Puerto Rican origin made up 7 percent of primary heroin admissions (6 percent were males and 1 percent were females)**

- **Source: Drug Policy Facts: Required reading-Heroin Chapter**

GA's 911 Medical Amnesty and Naloxone Access Law. The law states:

- The caller and the victim cannot be arrested, charged or prosecuted when you call 911 for medical assistance at the scene of a suspected drug overdose if law enforcement arrives and finds personal use amounts of drugs and drug paraphernalia.
- The caller and the victim cannot be arrested, charged or prosecuted when 911 is called at the scene of a suspected alcohol overdose if law enforcement arrives and finds alcohol, even if you are underage.
- • The caller and victim must remain at the scene until medical assistance arrives for immunity to apply.

- Source: Georgia Overdose Prevention.org



The Good Samaritan Law

- The Good Samaritan Law is a law that protects civilians who help people they believe to be injured or otherwise in danger. For example, the Good Samaritan Law provides people with the freedom to act without having to fear the other person might sue them. The purpose of the Good Samaritan Law is to encourage ordinary people to help someone in distress before the police are able to arrive.

States and Good Samaritan Laws

- All 50 states and the District of Columbia have a good Samaritan law, in addition to Federal laws for specific circumstances. Many good Samaritan laws were initially written to protect physicians from liability when rendering care outside their usual clinical setting

- Source: NIH National Library of Medicine

Are Good Samaritan Laws Effective?

- **A General Accountability Office (GAO) found that, despite some limitations, the findings collectively suggest a pattern of lower rates of opioid-related overdose deaths among states that have enacted Good Samaritan laws, both compared to death rates prior to a law's enactment and death rates in states without such laws.**
- **Source: Drug Policy Facts: Required reading-Prescription Heroin and Heroin Maintenance Chapter**

Study Findings:

- **In addition, studies found an increased likelihood of individuals calling 911 if they are aware of the Good Samaritan laws.**

- **Source: Drug Policy Facts: Required reading-Prescription Heroin and Heroin Maintenance Chapter**

Naloxone Access laws

- **Naloxone access laws that ease restrictions on naloxone possession and distribution are associated with a 20% reduction overdose deaths among African-Americans.**
- **These laws are effective at reducing overdose mortality without creating additional opioid use. Correspondingly, these measures should be considered an important part of the strategy used to address the opioid epidemic.**

States and Naloxone Access Laws

- As of August 2020, all 50 states and the District of Columbia have some form of a naloxone access law.

What is naloxone?

- Naloxone is a medicine that rapidly reverses an opioid overdose. It is an opioid antagonist. This means that it attaches to opioid receptors and reverses and blocks the effects of other opioids. Naloxone can quickly restore normal breathing to a person if their breathing has slowed or stopped because of an opioid overdose.

- Source: NIDA: Naloxone Drug Facts

Module 10: Illicit Drugs – Part 2 Cocaine and Crack

What We'll Cover

- History of Coca
- Forms of Cocaine: Powder, Freebase, Crack
- Prevalence of Cocaine Use
- United States Sentencing Guideline Commission
- Minimum Sentencing Guidelines for Crack Offenses
- Racial Disparities in Sentencing
- Crack Myths

History of Coca

- **Archaeological evidence has confirmed that the coca leaf has been cultivated and used by the indigenous people of the Andes region for at least 4,000-5,000 years while other estimates put this as far back as 20,000 years. By the time of the Spanish colonial conquest, coca use extended all the way from what is today Costa Rica and Venezuela, through the Brazilian Amazon (coca's place of origin) and on down to Paraguay, northern Argentina and Chile.**
- *Source: Forsberg, Alan, "The Wonders of the Coca Leaf," Accion Andina (Cochabamba, Bolivia: January 2011), p. 1.*

Powder Cocaine

- **The chemical name for powder cocaine is cocaine hydrochloride, which is created through a complex process of heating and cooling coca leaves. After pulverizing coca leaves into a coarse powder, alcohol is added and distilled off in order to extract the most pure form of cocaine alkaloid. Powder cocaine is ingested intranasally, through snorting, and takes effect within five to fifteen minutes; the euphoria lasts up to two hours.**
- **Source: Drug Policy Facts-Chapter on: Cocaine, Crack, Coca**

Cocaine Freebase

- **Cocaine freebase, first created in the 1970s, is smokeable. To create cocaine freebase, cocaine hydrochloride must be heated and then mixed with ammonia and ether. The substance cools and yields smokeable cocaine crystals after drying. Ether, an extremely flammable substance, renders the process of smoking cocaine freebase quite dangerous. After inhalation, cocaine reaches the brain within ten seconds, and the high lasts for up to five minutes.**
- **Source: Drug Policy Facts-Chapter on: Cocaine, Crack, Coca**

Crack

- **In the 1980s, a less dangerous form of cocaine freebase was invented: crack cocaine. When cocaine powder is mixed with baking soda to form a paste and heated, the substance hardens into rocks. This product was given the street name 'crack,' for the crackling sound it makes when smoked.**

Emergence of Crack

- In 1985, *The New York Times* became the first major media outlet to use the term 'crack cocaine,' and a follow-up article appeared on the front page less than two weeks later, detailing crack cocaine and its intensely addictive quality. By 1986, major news outlets had declared crack cocaine usage to be in 'epidemic proportions.'⁶⁹
- Beaver, Alyssa L., "Getting a Fix on Cocaine Sentencing Policy: Reforming the Sentencing Scheme of the Anti-Drug Abuse Act of 1986," *Fordham Law Review* (New York, NY: Fordham University School of Law, April 2010) Vol. 78, No. 5, p. 2539.
<http://fordhamlawreview.org/as...>

Estimated Prevalence and Trends in Use of Cocaine, Including Crack, in the US

- **Cocaine use includes the use of crack cocaine. Estimates of crack use are presented separately as well. Among people aged 12 or older, the percentage who were past year cocaine users decreased from 2.5 percent (or 5.9 million people) in 2002 to 2.0 percent (or 5.5 million people) in 2019.**
- **Drug Policy Facts-Chapter on: Cocaine, Crack, Coca**

Cocaine Use

- **Estimates of past year cocaine use among people aged 12 or older fluctuated over time. The percentage in 2019 was lower than the percentages in 2002 to 2007, was higher than the percentages in most years from 2011 to 2014, and was similar to the percentages in 2008 to 2010 and in 2015 to 2018.**
- **Drug Policy Facts-Chapter on: Cocaine, Crack, Coca**

Prevalence of Cocaine and Crack Use in the US **by Demographic Characteristics**

- In 2015, among people aged 12 and older in the United States:
 - 38,744,000 people had used cocaine at least once in their lifetime.
 - 4,828,000 people had used cocaine in the past year.
 - 1,876,000 people had used cocaine in the past month.
 - 9,035,000 people had used crack at least once in their lifetime.
 - 833,000 people had used crack in the past year.
 - 394,000 people had used crack in the past month.

- Drug Policy Facts-Chapter on: Cocaine, Crack, Coca



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Cracks in the System

- Anti-Drug Abuse Act of 1986
 - Establish mandatory minimum sentences for crack offenses
 - The United States Sentencing Commission concluded that crack was not appreciably different from powder cocaine in its chemical composition or physical reactions to users.
 - Nevertheless, Congress established much tougher sentences for crack cocaine offenses than for powder cocaine cases.

Crack vs. Powder

- Distribution of 5 grams of crack carries a minimum of 5-year federal prison sentence, while;
- For powder cocaine distribution of 500 grams—100 times the amount of crack cocaine, carries the same sentence.

- Source: Cracks in the System: Twenty Years of the Unjust Federal Crack Cocaine Law

Racial Disparities

- Because of relative low cost, crack cocaine is more accessible for poor Americans, compare to powder cocaine which is more expensive and tends to be used by affluent whites.
- African Americans are more likely to be convicted of crack offenses, while whites are more likely to be convicted of powder cocaine offenses.
- African Americans make up 15% of drug users but comprise 37% of those arrested for drug violations.
- Specifically with regard to crack, more than 80% of the defendants sentenced for crack offenses were African America.

• Source: Cracks in the System: Twenty Years of the Unjust Federal Crack Cocaine Law



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Longer Sentences

- The average sentence for a crack cocaine offense in 2003 (123 months) was 3.5 years longer than the average sentence of 81 months for an offense involving the powder form of the drug.
- From 1994-2003, the difference between the average time African American offenders served in prison increased by 77%, compared to an increase of 28% for white drug offenders.
- Source: Cracks in the System: Twenty Years of the Unjust Federal Crack Cocaine Law

Some Effects of Mandatory Sentencing

- The effects of mandatory sentencing not only contribute to disproportionately high incarceration rates, but also separate fathers and mothers from families, create massive disenfranchisement of those with felony convictions, and prohibit previously incarcerated people from receiving some social services.

- Source: Cracks in the System: Twenty Years of the Unjust Federal Crack Cocaine Law



Did Mandatory Minimum Penalties Target “serious” and Major “drug traffickers”

- Data from the Sentencing Commission shows that 73% of crack defendants have only low-level involvement in drug activity, such as street-level dealers, couriers, or lookouts.
- Source: Cracks in the System: Twenty Years of the Unjust Federal Crack Cocaine Law

Module 11: Marijuana

Cannabis is exceptionally complex

- Cannabis plant contains 400+ chemicals (61 are found nowhere else); different marijuana plants contain different mixtures of these complex components
- Two are carcinogenic – cause cancer (tar and benzopyrene)
- Marijuana less frequently used than cigarettes, but by far the most used illicit drug in the U.S.
- Difficult to categorize marijuana – effects vary
 - Psychopharmacologists originally placed it within ‘hallucinogens’ but today, many argue that it does not really fit in that category



Cannabis/Marijuana

- Cannabis sativa = scientific name for the marijuana plant most often used for 'head high'
 - Marijuana = dried buds, flowers, leaves of the cannabis plant
 - Hashish = the dried resin of the cannabis plant; usually more potent than marijuana. Sifting process used to collect pollen.
 - Oil = often referred to as CBD oil, more associated with relaxation than with a 'head high'
- Main psychoactive ingredient in marijuana is THC (tetrahydrocannabinol) – produces the 'head high'
- Recent research has also begun to explore CBD (Cannabidiol)



Cannabis Sativa vs. Cannabis Indica

- Botanical vs. Folk definitions
 - Colloquial use emphasizes differing user experiences (head high vs. relaxation), whereas botanical definitions emphasize very different parameters
- Many in the cannabis industry have moved away from terms of Sativa, hybrid, and Indica and begun classifying different “strains” as:
 - Type I: high THC
 - Type II: THC/CBD combined
 - Type III: high CBD

Cannabinoids

- Term for the 60+ chemical compounds found only in marijuana
- Of these compounds, only two have received systematic research
 - THC and CBD
- Corporations have synthesized THC (and the FDA has approved), but because marijuana is a 'schedule 1' drug, it is difficult to conduct research on the plant as opposed to synthetic compounds, and because it is a plant (and cannot be patented), companies do not have incentive to pay for expensive trials of the plant itself

Marijuana Production and Availability

- Interdiction vs. Eradication
 - Drug interdiction (preventing illicit drugs from reaching their destination) is important in stemming the flow of illegal drugs
 - Eradication (the physical destruction) of illicit crops remains an important tool for decreasing the production of illegal drugs and preventing them from entering the United States, or other drug markets.
- Because it has shifted its priority to fighting terrorists, Mexico has scaled down its eradication program, thereby boosting its potential supply to the U.S; Colombia and the Caribbean supply a substantial proportion of cannabis, especially in Florida and the East Coast.

Limits to Success of Interdiction and Eradication Efforts

- Interdiction is difficult because so many countries can export marijuana and so many avenues whereby it can be smuggled (Southern Border, Northern Border, but also airports and ports of entry)
 - When successful in limiting smuggling in one place, economic incentives (via higher prices) leads to increases in smuggling elsewhere. Interdiction, at best, can reduce supply and increase prices...it cannot remove supply.
- Moreover, three features of marijuana cultivation make the drug virtually impossible to eradicate:
 - The enormous range and variety of its sources
 - The adaptability of these sources, in that busting one operation opens up market opportunities for others
 - The cannabis plant's resilience and hardiness (can be grown virtually anywhere, including within the U.S.)

Acute Effects of Marijuana

- It is almost impossible to die of a marijuana overdose; one of the least toxic drugs known to humans
- Acute physical effects:
 - Red eyes, increased heart rate, dry mouth
 - Ataxia (physical discoordination)
- Decreased intra-ocular pressure and relaxation are also acute effects
 - linked to therapeutic use of marijuana for glaucoma as well as palliative relief for cancer patients

Self reported marijuana experiences:

- Most (but not all) users report positive/pleasurable experience
 - Also used to enhance pleasurable experiences
- Why do we utilize self reported data?
 - How else can we understand subjective experiences?
 - Sociologists take seriously the subjective meanings and experiences of those we study, and also recognize that groups, often more than individuals shape these interpretations.

Drug Fate: Metabolizing Marijuana and Potential Impacts on Addiction

- THC is stored in the body (fatty tissue) for long periods of time; takes 2-3 weeks for drug to be completely eliminated from the body
- Lingering traces/slow rate of elimination good and bad
 - Bad = drug never leaves the system of chronic users; may impair learning and coordination long after use
 - Good = abrupt discontinuation of marijuana does not produce classic withdrawal symptoms, unlike alcohol and heroin
- While not associated with physical dependence/addiction, about 1 in 11 users experience psychological dependence with marijuana use

Marijuana

- Patterns of use

- MTF survey reported large increase in teenage use during the 1990s; between 1991 and 2002 all levels of marijuana use increased for all grades
- NSDUH survey reports similar increase in teenage use (12- to 17-year-olds) for this time period although increase less steep
- Young people are beginning use at an increasingly young age (used to be age 15, now it is a year or two earlier)
- However, this increase in marijuana prevalence ended by the late 1990s, and even with the rise, it did not go back to the levels of the late 1970s, and marijuana use has always been much higher than other illegal drugs

Marijuana

- What explains 1990s upsurge in marijuana use among the young?
 - Baby Boom Echo – tolerant parents raise tolerant children
- Should we be worried? Some Concerns:
 - DUI and associated accidents/fatalities
 - Study about Airplane Pilot consumption (lowered coordination of pilots even 24 hours after they smoked)
 - While the effects last longer, studies have also found that the level of ataxia for marijuana use is much less than associated with alcohol.
 - May signal increased future use of harder drugs- discuss Gateway Hypothesis later, but notice now that correlation is not causation
 - Harmful medical consequences – e.g., impairment of short-term and long-term memory as well as reduced lung functioning (for heavy, chronic users)
...but contradictory findings suggest effects are likely weak

Politicizing Research on Marijuana

- In 1974, Senator James Eastland conducted a series of Senate committee hearings on Marijuana-Hashish Epidemic and Its Impact on United States Security
 - Actively sought out (and only included) negative findings
- Studies linked marijuana use to:
 - “Cerebral atrophy” – shrinking of brain
 - Lower testosterone level & impotence
 - Chromosomal damage, birth defects
 - Lung damage
- Politicization impedes forward movement in research



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Contradictory Research Findings...Is Marijuana Dangerous?

- Young Turks discuss study of damage caused by marijuana.
 - <https://www.youtube.com/watch?v=hDnZu2XRg7U>
- Notice the way that this group also politicizes research but in the opposite direction of Senator Eastland...this politicization on all sides makes it more difficult (though not impossible) for scientists to engage in free inquiry and develop a scientific consensus

Chronic Effects of Marijuana

- Problems with past (and existing) research?
 - Possible 3rd factor influence
 - Of the negative results discussed in the 1970s, only negative lung function continues to be explored, and the lack of clear results for even this element other than with heavy, chronic use suggests weak to moderate impacts as most.
- Recent research?
 - Some scientist suggest that marijuana may produce a dependence greater than we think; some have suggested it may also prime the brain's pathways for harder drugs, but evidence to date has not been persuasive (in my view)

The Gateway Hypothesis: Progression to More Serious Drugs

- What we know = (1) marijuana users more likely to use any and all illegal drugs than nonusers; (2) the more one uses, the greater the likelihood; (3) the earlier in life that one uses, the greater the probability that one will try other, harder drugs
- What we don't know is why these things are true
- 3 schools of thought
 1. Pharmacological school
 2. Sociocultural school
 3. The predisposition school

The Pharmacological School

- The pharmacological school = argues that properties of drug itself dictates drug-related behavior; focuses on interaction between marijuana and human brain
 - Something inherent in marijuana use itself – the experience of getting high on the drug, which is caused by its pharmacology – that leads to the use of and dependence on other drugs
 - Role of pleasure and tolerance?

The Sociocultural School

- The sociocultural school = argues that drug-related behavior is influenced by the norms users acquire through contact with specific social circles or groups
 - In addition to altering one's values and identity, using peers also provide opportunities to use harder drugs (consider issues of supply, learning to use a drug, etc.)

The Predisposition School

- The predisposition school = argues that the connection between marijuana use and harder drug use is that the kinds of people who are likely to engage in compulsive marijuana use are also the kinds of people who are likely to compulsively use harder drugs
 - Similar to problem-behavior proneness theory
 - The fact that someone is interested in experimenting with a state-altering substance like marijuana means that they are likely to be more interested in experimenting with other mind-altering drugs
 - What legal drug can we also attribute this school of thought to?
 - Is alcohol the ultimate gateway drug? Most often the first drug used (prior to marijuana, and most often used before legal age, so illicit at the time)



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Marijuana as Medicine

- 1975 – research demonstrates marijuana to be effective in reducing pain in cancer patients; subsequent research showed same for AIDS patients
- Government fears “foot in the door” in regards to legalization
- Currently, 20 states have legalized medical use (7 states recreational); both of these are changing/increasingly yearly it seems...
- Federal law still supersedes state law; doctors/pharmacists can be prosecuted
- Reasons to remain skeptical...research has not used large-scale, double-blind, experimental, gold-standard methods (because these are usually paid for by pharmaceutical companies and also made more difficult by current scheduling of marijuana- a ‘catch 22’ situation). But this skepticism should push us towards research on these open possibilities, not denial of research and continuing of status quo.

Module 12: Drug Trafficking

Outline

In this module, we address the following:

- Availability, price, purity, and source of trafficked substances
- The myth of market centralization
- Is the drug trade a pure economic liability?
- Where do illicit drugs come from?
- Factors that facilitate the drug trade
- The street-level economics of heroin abuse
- Class and ethnic styles of dealing
- How the drug trade harms source countries

Availability, Price, Purity, and Sources

The illegal drug trade is a huge enterprise with annual revenues of the global narcotics industry exceeding **half a trillion dollars**. To put this in perspective, this is:

- Three times the value of all United States currency in circulation
- More than the gross national products of all but a half-dozen of the major industrialized nations

What the U.S. Spends on Illicit Drugs

Please read the following reports on total expenditure on illicit drugs:

- <https://www.rand.org/news/press/2019/08/20.html>
- https://www.rand.org/pubs/research_reports/RR3140.html

Myths Surrounding Illicit Drugs

There are a number of persistent myths with regard to the illicit drug trade. We will briefly mention three of them on the following slides

1. The Myth of the Size of the Drug Trade

- Although the drug trade is large, it is much smaller than numerous inflated estimates have had it
- It is untrue that people spend more money on drugs than on any other consumer product in existence

2. The Myth of Market Centralization

- The second myth is that the industry is highly hierarchical, centralized, and highly structured (akin to the Mafia)
- Over the past three decades, much of the illicit drug market has become splintered and extremely decentralized
- Different traffickers operate in hundreds, possibly thousands, of independent enterprises

3. The Myth of the Drug Trade as an Economic Liability

- The third myth centers around the economic harm to the nation from illicit drug use, namely that Schedule 1 drugs represent an unmixed deficit to the economy
- Drug sales support the industry in more or less the same way as all other industries, regardless of whether they are legal or illegal
- The drug trade not only supports the people who work for it but also those who work for the legal sector of the economy that drug workers patronize
- The obliteration of the drug industry would wipe out these jobs in exactly the same way that the demise of the corn, coffee, automobile, or computer industry would



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Where Do Illicit Drugs Come From?

- Pure agricultural model: A pattern of drug distribution that applies to substances harvested from plants that contain drugs, requiring little or no preparation or transformation
 - Applies mainly to marijuana and opium
- Pure chemical model: A pattern of drug distribution that applies to substances produced entirely in the lab
 - Examples: Ecstasy, L S D, and methamphetamine

Where Do Illicit Drugs Come From?

- Mixed model: A pattern of drug distribution involving both growing a drug-bearing plant in an agricultural setting and chemically extracting its drug for distribution and sale
- Examples: Heroin and cocaine

Where does Heroin come from?

- Golden triangle: The area of Southeast Asia in which opium poppies grow
 - Includes Burma, Laos, Cambodia, and Thailand
- Golden crescent: A region of Western Asia in which opium poppies are grown
 - Includes Iran, Afghanistan, Pakistan, and Eastern Turkey
- Today, heroin in the United States either comes from Mexico (90%) or South America (10%)
- Worldwide: Most originates from Afghanistan



Where does Cocaine come from?

- Nearly all the cocaine consumed in the United States comes from Colombia, Peru, or Bolivia, with Colombia contributing the lion's share
 - 92% comes specifically from Colombia
- In the past two or three decades, Mexican traffickers have played a growing and now major role in the operation of the cocaine trade

Where does Marijuana come from?

- At least half of America's marijuana is grown domestically
- Most of the remainder comes from Mexico, some from Colombia, and some from Central America
- It is the drug most likely to be produced directly by consumers

Where does Methamphetamine come from?

- Methamphetamine consumed in the United States is likely to come from one of two sources
 - China, Canada, or large labs in Mexico run by a centralized organization
 - Small, scattered labs in the United States
- Available almost everywhere in the United States, particularly in the West and Midwest

Where does Ecstasy come from?

- Ecstasy is manufactured mainly in Belgium and the Netherlands
- Most of the Ecstasy currently consumed in the United States comes from three sources
 - China, Southeast Asia, and Canada
- Asian drug trafficking organizations produce substantial quantities of Ecstasy in Canada and smuggle it across the border into the United States

Where does LSD come from?

- Manufacturing L S D is an extremely difficult, time-consuming, and complex process, requiring a great deal of chemical sophistication
- Perhaps as few as a dozen labs in the United States supply nearly all of the L S D consumed in the country
- Manufacturers tend not to involve themselves in distributing the drug, but sell it to a very small number of trusted associates

Factors That Facilitate the Drug Trade

- A number of factors have contributed to the explosion of the globalization of the drug trade
 - The most basic, fundamental, and absolutely crucial factor is prohibition
 - A growing worldwide trend away from government control of the economy and toward economic privatization
 - The worldwide movement toward becoming a borderless world
 - Poverty exists at either end of the distribution spectrum, at least for our two mixed products: heroin and cocaine
 - Weak or corrupt local and federal governments



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Factors That Facilitate the Drug Trade

- Organized Crime Models (UNODC Report):

<https://www.unodc.org/e4j/en/organized-crime/module-3/key-issues/drug-trafficking.html>

The Street-Level Economics of Heroin Abuse

- The ultimate economic transaction is that which takes place between the street seller and the user
- Transactions made by heroin abusers provide a look at how drug sales actually take place
- Journalists, the public, and even some researchers often have an inflated notion of how much money heroin users, abusers, and addicts spend on their drug

The Street-Level Economics of Heroin Abuse

- Heroin abusers receive a substantial proportion of their heroin by serving as the day laborers of the heroin-distribution industry
- Heroin users, abusers, and addicts do regularly victimize others by committing classic predatory crimes against them
- In sum, the economic functions of drug-related crime are not simple

Class and Ethnic Styles of Dealing

- Street styles of drug dealing may help explain at least a portion of racial disparities in drug-related arrests
- The middle-class style entails dealing in private to customers known to the seller, dealing in larger quantities a smaller number of times, and dealing in locales in which violence rarely or never takes place

Class and Ethnic Styles of Dealing

The inner-city style entails:

- Dealing typically to strangers
 - Dealing small quantities
 - Dealing in public and semi-public places
 - Dealing in locations in which violence often takes place
-
- Arrest is far more likely to take place under the latter conditions than the former

Patterns of Drug Distribution

- <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1975811/>
- Profile of meth dealer:
- <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3197264/>

Highlight: Afghanistan in the Era of Fentanyl

- <https://www.rand.org/pubs/perspectives/PEA1088-1.html>

Module 13:

Drugs and Crime

Outline

- The relationship between drug use and crime
- Drugs and crime: Three models
- The drugs-violence nexus: Three models
- The role of cocaine use in violent behavior
- Heroin addiction and violence
- Alcohol and violence

The Drug-Crime Link

- There is a connection between drug use and crime
 - People who use drugs are much more likely to commit nondrug crime than nonusers
 - People who commit crime are much more likely to use drugs than people who do not commit crime
- Connection between certain drugs, such as heroin and crack cocaine, is vastly stronger than that between others, for instance, L S D and Ecstasy

The Drug-Crime Link

- Criminogenic refers to having the capacity to cause or influence the commission of criminal behavior
- Dependent variable is a factor that is caused by another factor, called the independent variable
 - Example: Age (an independent variable) causes drug use (a dependent variable)
- Independent variable is a factor that directly causes another factor

The Relationship between Drug Use and Crime

- The link is completely unproblematic
 - Hardly any criminologist or sociologist of deviance or drug use questions that drugs and crime are empirically related
- The more frequently persons use drugs for recreational purposes:
 - The greater the likelihood that they engage in criminal behavior
 - The greater the likelihood that they will do so frequently
 - The more serious the criminal behavior they engage in
- Drug selling influences nondrug crimes
- The National Survey on Drug Use and Health (NSDUH) documents the relationship between drug use and being arrested and prosecuted for illegal behavior

Drugs and Crime: Three Models

- The enslavement model
- The predisposition model
- The intensification model

The Enslavement Model

- Argues that more or less accidental or fortuitous narcotic addiction causes a life that revolves around engaging in money-making crimes
 - It is drug addiction that causes criminal behavior
- If addicting drugs were dispensed in clinics, the link between drug addiction and a life of crime would be severed

The Predisposition Model

- Argues that the kinds of people who are likely to engage in compulsive drug-taking behavior are also the kinds of people who are likely to engage in criminal behavior
- Argues against and opposes the enslavement or medical model
- Drugs and crime are two sides of the same behavioral syndrome

The Intensification Model, 1

- Argues that the enslavement and the predisposition models contain a grain of truth, yet as complete explanations, they are flawed in that they are based on an unarguably false empirical premise
- Contrary to what the enslavement model argues, juvenile crime frequently precedes drug use
- Contrary to what the advocates of the predisposition model might predict, when addicts abstain from the use of narcotics, their crime rate plummets
- Neither the enslavement nor the predisposition model is completely faithful to the facts

The Drug-Violence Nexus: Three Models

- The psychopharmacological model
- The economic-compulsive model
- The systemic model

The Psychopharmacological Model

- The most commonsensical and traditional explanation of why drugs and violence are connected
- Proponents of this line of thought hold that it is the psychological and physical effects of psychoactive substances that cause users to become violent toward others

The Economic-Compulsive Model

- Researchers argue that because addicts need to raise large sums of money quickly, they engage in high-risk crimes, including theft, robbery, and burglary
 - Often escalate into acts of physical harm against the victim
- Economic crimes undertaken to support a drug habit do not always remain simple property crimes

The Systemic Model

- Systemic violence in this model refers to the traditionally aggressive patterns of interaction within the system of drug distribution and use
- It is normatively embedded in the social and economic networks of drug users and sellers

Which Model Makes the Most Sense?

- Researcher Paul Goldstein and his colleagues argue that the systemic model best explains the facts
- Looking at a sample of criminal homicides in the city of New York during the late 1980s, at the height of the crack epidemic, they found that half were drug related, and of the ones that were drug related, 60 percent were crack related
- It became clear that very few of the crack-related homicides (3%) were psychopharmacological in origin and relatively few (7%) also were economic-compulsive in origin
 - The vast majority were systemic

The Role of Cocaine Use in Violent Behavior

- Violence tends to be gendered
- As men's cocaine abuse increases, their likelihood of being the perpetrator of violence increases
- As women's cocaine abuse increases, their likelihood of being the victim of crime increases

Heroin Addiction and Violence

- Polydrug use: The use of more than one drug, whether at the same time or during a given period of time
- Cocaine and violence are frequent companions
 - The greater the amount of cocaine someone uses, the greater the likelihood, and the seriousness, of violent behavior
- Prior to the 1970s, most researchers thought of the heroin addict as basically peaceful
- Beginning in the early 1970s, a new view of heroin addicts emerged
 - Their tendency to commit violence was significantly greater than that of the ordinary criminal or property offender
- The world moved toward younger users, who took many drugs, including alcohol and cocaine, in addition to heroin
 - These users were more likely to confront their victims in robberies rather than relying on stealth
- The 1970s marked the coming of a new breed of heroin addicts



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Alcohol and Violence

- Drunken comportment: Behavior under the influence of alcohol
- Cognitive guidedness approach: The argument that behavior under the influence of alcohol is guided by cultural norms, rarely straying far from what is culturally acceptable
- Disinhibition model: The proposition that alcohol more or less automatically releases inhibitions and causes violent behavior in the violently inclined
 - Assumes that the effects of alcohol cause what drinkers do under the influence, violence included

Alcohol and Violence

- Alcohol is a legal drug, but statistically, drinkers have higher rates of violence than nondrinkers
- Some researchers believe that alcohol is the culprit
 - They argue that alcohol disinhibits behavior, neutralizing the centers of our brains that force us to think twice about striking out at our fellow men and women
- Other researchers believe that our behavior is cognitively guided by the cultural norms, not pharmacologically guided by alcohol
- Even though cultural norms do influence and limit our behavior, alcohol disinhibits
 - The disinhibition sometimes results in violent behavior
- A substantial slice of the alcohol-violence link is psychopharmacological in nature



Module 14: Drug Law & Drug Treatment

Outline

In this module, we address the following:

- Drug use, the crime rate, arrest, incarceration trends
- Prohibition: Two punitive arguments
- Drug control: The current system
- Does prohibition work?
- Drug courts: Treatment, not punishment
- Drug Treatment Models

Drug Use, the Crime Rate, Arrest, Incarceration

- While some indicators of drug use and most indicators of criminal behavior have declined, arrests and incarceration rates for drug possession, sale, and criminal behavior have sharply increased
 - See the UNODC data: <https://dataunodc.un.org/>
- Since 1970, the total number of prisoners in state and federal penitentiaries has increased by seven times
 - See the PEW report on Drug-related arrests: <https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2022/02/drug-arrests-stayed-high-even-as-imprisonment-fell-from-2009-to-2019>

World Drug Report, 2017

Please click the link below and browse the 2017 UNODC World Drug Report

<https://www.unodc.org/wdr2017/index.html>

Prohibition: The Punitive Model

- Proponents of this perspective call for a policy of punishing persons who ignore the law and partake in a specific banned or illegal activity, service, or product
- The term “prohibition” refers to a punitive or criminalizing approach to dealing with troublesome behavior
- Under drug prohibition, criminal penalties are applied to the possession and sale of controlled substances
- Prohibitionists believe that the application of criminal penalties will reduce or contain drug use

Two Punitive Arguments

- Deterrence argument: The view that punishing a given activity will deter or decrease its incidence
- Punitive or prohibitionist argument comes in two very different varieties
 - Absolute deterrence: The view that punishing a given activity will eliminate or drastically reduce the incidence of a given activity
 - Relative deterrence: The view that, in the absence of law enforcement, the incidence of a given activity would be greater than it is with law enforcement

Drug Control: The Current System

- The United States has a mixture of drug policies for different drugs
- The *legal* drugs, like alcohol and tobacco, are regulated, available to anyone above a certain age but bought and sold under restrictions set by law
- For the completely legal drugs, the use of a given substance is not in question
- Possession and sale for the purpose of just about any and all use are legal
- The matter is quite different for the prescription drugs. The *prescription* drugs are available with a physician's prescription for specified medical purposes
 - It is the use of the drug that defines its legal status
- Other substances, such as the one categorized as **Schedule 1 drugs** are completely outlawed
 - Follow this link to the CSA and read about how different substances are categorized!
 - <https://www.dea.gov/drug-information/csa>



Drug Control: The Current System

- In our current system of drug control, a range of psychoactive substances are regulated by the criminal law (**Controlled Substances**)
- The Controlled Substances Act was first introduced in 1970 and provides for schedules or categories of drugs with varying controls and penalties for violations
- Link to the CSA: <https://www.dea.gov/drug-information/csa>
- Link to the definition of the 5 Schedules with examples: <https://www.dea.gov/drug-information/drug-scheduling>

Drug Control: The Current System

- The medical or prescription model is used for psychoactive pharmaceuticals such as Valium, Halcion, morphine, Prozac, Thorazine, and marijuana
- A criminalization or punitive model is used for illegal drugs and a variety of prescription drugs that are completely illegal if used recreationally or without prescription

Does Prohibition Work?

- An enormous volume of research has been conducted on the impact of drug prohibition

ACTION ITEM: Please see the links provided for readings and videos on this topic in the module folder

- Severity in penalties for drug possession and sale has no deterrent effect whatsoever
- Sealing the borders of the United States does not reduce consumption because the country's borders are extremely porous

Does Prohibition Work?

- If there were no arrests, no seizures, no inspections at the border, and no eradication programs, it is certain that the availability of drugs would be vastly greater than it is currently
- Law enforcement cannot possibly wipe out or drastically reduce illicit drug supply or demand
- To the extent that law enforcement works, it prevents a flood from becoming a tidal wave

Drug Courts: Treatment, Not Punishment

- In jurisdictions around the country, alternatives to incarceration have been instituted
- Drug courts offer the nonviolent drug offender a program of diversion from the criminal justice system into some sort of treatment program
- Information on Drug Courts:
<https://nij.ojp.gov/topics/articles/overview-drug-courts>
- Some research shows that drug court clients are more likely than controls to participate in continued drug treatment and drug testing and less likely to be rearrested
- However, programs usually work better if there are frequent urine tests, routine appearances before the judge, active enrollee treatment participation, and the threat of sanctions if the enrollee does not meet program goals

Drug Treatment

- Drug treatment is designed to reduce drug use, or the harm associated with drug use, through a means other than law enforcement
- The Medical Model argues that drug use is a medical problem and should be dealt with by medical means
- Usually entails a proposal to emphasize treatment over incarceration
- Some important qualifications need to be established before measuring the effectiveness of drug treatment programs
- Reducing drug use or abuse to zero is an extremely unrealistic goal and there is variability in effectiveness from one program to another

Drug Treatment

- Four principal types of drug treatment programs, or treatment modalities, currently prevail in the United States
 - Methadone maintenance
 - Therapeutic community (or TC)
 - Outpatient, drug-free programs
 - Self-help peer groups, such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA)

Drug Treatment

- Methadone maintenance: A program of maintaining narcotic, mainly heroin, addicts on a narcotic drug (methadone), which reduces their craving for, and makes it difficult to become high on, recreational doses of narcotics
- Therapeutic community: A live-in drug treatment program that seeks abstinence as its goal
- Self-help peer groups: Cost-free, not-for-profit, local, autonomous, self-supporting groups

Drug Treatment

- Drug Abuse Reporting Program (DARP): A study conducted between 1969 and 1972 to determine the effectiveness of drug treatment programs
- Information on DARP: <https://ibr.tcu.edu/projects/completed-projects/darp-project-summary/>
- Drug treatment programs represent another crack in the armor of a strict “lock them up and throw away the key” policy toward illicit drug use
- Drug treatment is based on a pathology or medical model

Module 15: Legalization & Decriminalization

Outline

- Legalization: An introduction
- Is drug criminalization a failure?
- Four proposals to reform the drug laws
- Will drug use/abuse rise under legalization?
- What is to be done?

Legalization: An Introduction

- Many critics and observers argue that the system of prohibition that currently prevails in the United States does not work and is counterproductive
- The very nature of legal prohibition makes obtaining a banned product or a service expensive and, hence, profitable to supply
- The illicit drug business breeds corruption, brutality, violence, and crime, not to mention tainted drugs of unpredictable quality

Why Do Legalizers Believe Criminalization Cannot Work?

- Criminalization makes illegal drugs expensive and, hence, profitable to sell
- The currently illegal drugs are less harmful than the currently legal drugs
- Prohibition is futile because criminalization does not deter use
- Prohibition encourages the distribution and use of harder drugs

Why Do Legalizers Believe Criminalization Cannot Work?

- Drug dealers sell in a market in which there are no controls whatsoever on the purity and potency of their product
- Hence, users are always consuming contaminated and dangerous substances
- Undercutting the profit motive would force organized crime out of the drug trade
- The current level of drug-related violence is solely a product of the illegality of the drug trade

Why Do Legalizers Believe Criminalization Cannot Work?

- By placing a huge priority on the drug war and encouraging the arrest of dealers, the government has opened the door to the violation of the civil liberties of citizens on a massive scale
- Considering the enormous cost and the staggering tax burden of enforcing prohibition, billions of our tax dollars are being wasted in a futile, harmful endeavor
- Useful therapeutic drugs that are now banned by the government would be reclassified so as to take their rightful place in medicine

Four Proposals to Reform the Drug Laws

- Legalization
- Decriminalization
- Prescription and maintenance models
- Harm reduction

Legalization

- A policy permitting the possession and sale of drugs under a government licensing system similar to that controlling the distribution of alcohol and/or cigarettes
- Presumably, the government would control issues such as drug advertising and determine:
 - Who may sell drugs and in what sort of establishment
 - Who is permitted to manufacture them
 - Where and under what circumstances they may be used

Decriminalization

- Partial decriminalization: A policy whereby the possession of a small quantity of a controlled drug does not result in arrest
 - If the possessor is apprehended by law enforcement, the possessor is fined and the drug is confiscated
- Full decriminalization is a complete hands-off or laissez-faire policy toward drugs
 - Anyone above a certain age may legally possess or sell any quantity of any drug without legal penalty

Prescription and Maintenance Models

- Medical approach: The argument that the problem of all drug use, illicit drug use included, is a medical problem and should be dealt with by medical means
- Usually entails a proposal to emphasize treatment over incarceration
- Prescription model: A drug policy that proposes that drugs be administered by prescription

Prescription and Maintenance Models

- Maintenance model: The view that the drug problem could be solved or alleviated if users, abuser, and addicts were maintained on their drug of choice
- The model may be applied to a specific drug or drug type, or drugs in general
- Some observers recommend that drug abuse be regarded as a medical matter and that Schedule 1 drugs be rescheduled as Schedule 2 drugs

Harm Reduction

- Argues that the purpose of the law is not to wipe out drug use or abuse but to reduce the total volume of harm to the society, including death, disease, a decline in productivity, educational deficits, monetary cost, and so on
- Harm reductionists treat each drug on a case-by-case basis and every detail of every proposal on a case-by-case basis

What about Marijuana?

- Between 1969 and 2017, the proportion of respondents saying that marijuana should be legal grew from 12 to 64 percent
- As of February 3, 2022, 37 states, four territories and the District of Columbia allow the medical use of cannabis products.
- As of November 29, 2021, 18 states, two territories and the District of Columbia have enacted measures to regulate cannabis for adult non-medical use.
- Public consumption of cannabis and its sale to and possession and use by minors are illegal everywhere

National Alcohol Prohibition (1920–1933)

- The Eighteenth Amendment (the Volstead Act) is the only constitutional amendment to have been repealed in American history
- Some legalizers argue that no ban or prohibition on an activity or substance that is desired by a sizable number of citizens will ever be successful
- The legalizers may be referred to as anti-prohibitionists
- Their guiding model for this position is national alcohol prohibition (1920–1933)

Legalization and Use: Two Issues

- The question of the impact of legalization on the incidence and frequency of use pivots on two separate questions: one empirical and the second moral and ideological

Legalization and Use: Two Issues

- The empirical question is familiar to us all and can be stated simply, although answered with difficulty and only tentatively
- What evidence do we have for the impact of legalization on use?
- The moral question is a bit harder to spell out, but need not detain us here, since it is essentially unanswerable
- If legalization does result in an increase in use, how many more users and abusers represent an acceptable increase, given the benefits that this change will bring about?



Worst-Case Scenario

- Some opponents of legalization argue that legalization will mean that countries will plunge into anarchy, families will disintegrate, and most of us will become drugged zombies
- In reality, it is highly unlikely that the use and abuse of cocaine or heroin would increase 10 times if any of the currently debated legalization plans were put in place

Will Drug Use/Abuse Rise under Legalization?

- Factors in the legalization-use/abuse equation
 - Human nature
 - Drug use and effects
 - Frequencies of use
 - The hassle factor
 - Cost



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Human Nature

- Legalizers and prohibitionists hold contrasting assumptions about human nature
- Legalizers see human nature as basically rational, sane, temperate, and wise
- The reason why drug abuse will not rise sharply under legalization is that most people are cautious and not willing to take risks
- Prohibitionists believe that many of us are willing to take dangerous risks and that a substantial number of us believe bad things happen to other people but not to us
 - The prohibitionists argue that a lot more people are reckless risk takers than the legalizers think



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Drug Use and Effects

- Although all drugs are by definition psychoactive, not all drugs are used in the same way
- Although all drugs are used for their pleasurable effects, the way that that pleasure is experienced and integrated into the lives of users is far from identical for all drugs
- Although all the psychoactive drugs possess a potential to generate a dependence in users, that potential varies enormously from drug to drug

Frequencies of Use

- The national alcohol prohibition in the United States (1920–1933) did discourage use
- Fewer Americans drank and fewer contracted cirrhosis of the liver during Prohibition than before and afterward
- The partial decriminalization of small quantities of marijuana in the states of the United States has not resulted in a significant increase in the use of this drug
- Several pieces of evidence suggest that when the availability of certain drugs increases, their use increases as well
- Under almost any proposed legalization plan, the currently illegal drugs would be more readily available



The Hassle Factor, 1

- Hassle factor is the trouble or difficulty of obtaining illicit drugs
- Addicts are pulled into use by the fact that they enjoy getting high, but they are pushed away from use by the fact that they have to commit crime to do so
- Street crime is difficult, risky, and dangerous
- If drugs were less of a hassle to obtain, the majority of addicts and abusers would use it more
- In this sense, then, the drug laws and their enforcement have cut down on the volume of drug use among a substantial proportion of our heaviest users and abusers
- Law enforcement controls major aspects of the hassle factor, and drug use is most decidedly elastic with respect to hassle



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Cost

- In the absence of prohibition, heroin and cocaine are as cheap as aspirin to manufacture
- Under any conceivable or proposed legalization plan, they would be vastly less expensive than they are now
- Under any and all legalization plans, the currently illegal drugs would be sold or dispensed at a fraction of their present price
- Indeed, that is the advantage of this plan, say its supporters, because the high cost of drugs leads to crime which, in turn, leads to a wide range of social harms, costs, and problems

What Is to Be Done?

- Target, monitor, and test known drug offenders
- Apply the principle of triage
 - Focus drug treatment on those who most need it, allowing intensive and higher-quality treatment for those who need it most
- Expand maintenance programs for heroin addicts
- Study treatment programs empirically, find out which ones work, support those that are most effective, and improve the least effective ones

What Is to Be Done?

- Drug screening should be routine, and drug-positive patients should be referred to treatment
- Disrupting and eliminating deeply entrenched, mature drug markets is an unrealistic expectation
- Law enforcement efforts should be oriented toward controlling and reducing violence

What Is to Be Done?

- Disrupting international trafficking is unlikely
- Drug enforcement in producer countries should be oriented toward protecting local residents from harm rather than on reducing drug supply and use
- Increase support for empirically based drug prevention programs

Further Suggestions by Experts

- Be realistic about tobacco consumption
- Stop punishing former dealers and recovering drug addicts
- Get most drug dealers out of prison
- Explore positive incentives, such as cash payments, for former addicts testing clean
- Expand harm reduction programs to prevent heroin overdoses
 - Needle exchange
 - Supervised injection sites
 - Distribution of naloxone kits
- Fund studies that conduct research on the medical uses of currently illicit drugs

