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Drug Abuse

As a nation, we have been in the War on Drugs for the past 30 years. It has been referred to as a war with “no rules, no boundaries, no end” (PBS 2000). Since the mid 1980s, the United States has adopted a series of aggressive law enforcement strategies and criminal justice policies aimed at reducing and punishing drug abuse (Fellner 2000). Changes in federal law require all sentenced federal offenders to serve at least 87 percent of their court-imposed sentence. Many drug offenders are subject to mandatory minimum sentences based on the type and quantity of drug involved in their arrest (Scalia 2001). According to the Uniform Crime Report, 1,532,000 drug arrests were made in 1999, up from 580,900 in 1980 (Bureau of Justice Statistics 2003). Although some consider the increase in drug arrests a good sign, critics charge that mandatory sentencing denies drug users what they really need, access to treatment. Tougher sentencing has failed to decrease the availability of drugs and has failed to reduce illicit drug use. In addition, some argue that the focus on drug-related crimes has distracted law enforcement from monitoring more serious crimes.

On the prevention front, there was a new in-your-face public service campaign after the September 11, 2001, terrorist attacks. The Office of National Drug Control Policy [ONDCP] released a series of public service commercials linking the sales of illicit drugs with terrorism. One commercial featured a drug user named “Dan.” The commercial voice over says, “This is Dan. This is the joint that Dan bought.” The ad continues, ending eventually with the terrorist that Dan supported (Teinowitz 2002). Although the drugs and terrorism campaign generated much public attention and debate, the commercials were considered ineffective. The campaign officially ended in May 2003 when the ONDCP decided to switch to a traditional campaign targeting young people already using drugs (Teinowitz 2003).

There seems to be no argument about the seriousness of the drug problem in the United States. According to a 2002 National Survey on Drug Use and Health, 19.5 million Americans ages 12 and older reportedly were current illicit drug users (Substance Abuse and Mental Health Services Administration [SAMHSA] 2003c). It is estimated that 1 in every 13 adults or nearly 14 million people are alcoholics (National Institute on Alcohol Abuse and Alcoholism [NIAAA] 2003d). Although we might focus first on a single drug user and his or her personal trouble with drugs, it doesn’t take long to recognize how drug use has impacts on the user’s family and friends,

workplace or school, and neighbors and community. Throughout this chapter, we will examine the social problem of drug abuse, reviewing its extent, its social consequences, and our solutions. We begin first with a look at how the sociological perspectives address the problem of drug abuse.

Sociological Perspectives on Drug Abuse

Biological and psychological theories attempt to explain how alcohol or drug abuse is based in the individual. Both perspectives assume that there is a little a person can do to escape from their abuse: Their abuse is genetic or inherited. Abuse may emerge from a biological or chemical predisposition or from a personality or behavioral disorder. Such explanations also have consequences for treatment. Programs are directed at the individual, arguing that the abuser needs to be “fixed.” Although both perspectives have been important in shaping our understanding of drug abuse, these perspectives cannot explain the social or structural determinants of drug abuse. In this next section, we will examine how sociological perspectives address the problems of alcohol and drug abuse.

Functionalist Perspective

Functionalists argue that society provides us with norms or guidelines on alcohol and drug use. A set of social norms identify the appropriate use of drugs and alcohol. Drugs, prescription drugs in particular, are very functional. They alleviate pain, reduce fevers, and curb infections. Alcohol in moderation may be routinely consumed with meals, for celebration, or for health benefits. At least one glass of red wine a day has been shown to reduce one’s risk of heart disease.

In addition, society provides norms regarding the excessive use of drugs. For example, college students share the perception that excessive college drinking is a cultural norm (Butler 1993); this perception is enforced by the media and advertisers (Lederman et al. 2003). Aaron Brower (2002) argues that binge drinking is determined by and is a product of the college environment. Unlike alcoholics, college students are able to turn their willingness to binge-drink on and off depending on their circumstances (e.g., whether they have to study for an exam).

Drug abuse can also occur when society is unable to provide guidelines for our behavior. To explain drug abuse, functionalists rely on Emile Durkheim’s theory of **anomie**. Durkheim believed that under conditions of rapid cultural change, there would be an absence of common social norms and controls, a state he called anomie. If people lack norms to control their behavior, they are likely to pursue self-destructive behaviors like alcohol abuse, he thought (Caetano, Clark, and Tam 1998). During periods when individuals are socially isolated (such as moving to a new neighborhood, experiencing a divorce, or starting a new school year), they may experience high levels of stress or anxiety, which may lead to deviant behaviors, including drug abuse.

Conflict Perspective

Although many drugs can be abused, conflict theorists argue that intentional decisions have been made over which drugs are illegal and which ones are not. Powerful

political and business interest groups are able to manipulate our images of drugs and their users. Heroin, opium, and marijuana were considered legal substances in the late 18th and early 19th centuries; but public opinion and law changed when their use was linked to ethnic minorities and crime.

Katherine Beckett (1995) and Dorothy Roberts (1991) describe how women of color have been unfairly targeted in the war on drugs. As crack cocaine use spread throughout the inner cities in the 1980s, prosecutors shifted their attention to drug use among pregnant women, making drug and alcohol abuse during pregnancy a crime. The approach treated pregnant drug users as criminals and was “aimed at punishing rather than empowering women who use drugs during their pregnancy” (Beckett, 1995: 589). Beckett (1995) explains, “Prosecutions of women for prenatal conduct thus create a gender specific system of punishment and obscure the fact that male behavior, socio-economic conditions, and environmental pollutants may also affect fetal health” (p. 588).

Roberts (1991) argues that poor Black women were the primary targets for prosecutors. Research indicates that African American women are about 10 times more likely than other women to be reported to civil authorities for drug use. Public health facilities and private doctors are more inclined to turn in pregnant Black women than pregnant White women who use drugs. Are they being prosecuted for their drug use or for something else? Roberts (1991) states, “Society is much more willing to condone the punishment of poor women of color who fail to meet the middle-class ideal of motherhood” (p. 1436).

Feminist Perspective

Theorists and practitioners in the field of alcohol and drug abuse have ignored the experiences unique to women, ethnic groups, gay and lesbian populations, and other marginalized groups. Women face unique social stigmatization as a result of their drug use and may also experience discrimination as they attempt to receive treatment (Drug Policy Alliance 2003b). It wasn't until the 1970s that the scientific literature addressed women's addiction.

Specifically, there has been a lack of sensitivity to the range of drug abuse experiences, beyond the male or White perspective. Early prevention and treatment models treated female abusers no differently than men. However, there is increasing recognition of the importance of gender-specific and gender-sensitive treatment models, including the development of separate women's treatment programs. Female users have a variety of different treatment and psychosocial needs, influenced by their backgrounds, experiences, and drug problems. For example, single career-oriented women without children will have different treatment needs and priorities than single mothers or married mothers (National Clearinghouse for Alcohol and Drug Information [NCADI] 2003b).

Gail Unterberger (1989) offers a feminist revision of the traditional 12-step statement used by Alcoholics Anonymous. As originally written, the 12 steps send a negative message for women, reinforcing feelings of powerlessness and hopelessness during recovery. Unterberger believes that alcoholic women are more likely to suffer from depression than their male counterparts, and unlike men, women alcoholics may turn their anger on themselves rather than others. Unterberger's revised 12-step statement is presented in Table 1.

❖ Table 8.1 The 12 Steps for Women Alcoholics

1. We have a drinking problem that once had us.
2. We realize that we need to turn to others for help.
3. We turn to our community of sisters and our spiritual resources to validate ourselves as worthwhile people, capable of creativity, care, and responsibility.
4. We have taken a hard look at our patriarchal society and acknowledge those ways in which we have participated in our own oppression, particularly the ways we have devalued or escaped from our own feelings and needs for community affirmation.
5. We realize that our high expectations for ourselves have led us either to avoid responsibility and/or to overinvest ourselves in others' needs. We ask our sisters to help us discern how and when this happens.
6. Life can be wondrous or ordinary, enjoyable or traumatic, danced with or fought with, and survived. In our community we seek to live in the present with its wonder and hope.
7. The more we value ourselves, the more we can trust others and accept how that helps us. We are discerning and caring.
8. We affirm our gifts and strengths and acknowledge our weaknesses. We are especially aware of those who depend on us and our influence on them.
9. We will discuss our illness with our children, family, friends and colleagues. We will make it clear to them (particularly our children) that what our alcoholism caused in the past was not their fault.
10. As we are learning to trust our feelings and perceptions, we will continue to check them carefully with our community, which we will ask to help us discern the problems we may not yet be aware of. We celebrate our progress toward wholeness individually and in community.
11. Drawing upon the resources of our faith, we affirm our competence and confidence. We seek to follow through on our positive convictions with the support of our community and the love of God.
12. Having had a spiritual awakening as a result of these steps, we are more able to draw upon the wisdom inherent in us, knowing we are competent women who have much to offer others.

Source: Unterberger 1989.

❖ PUTTING IT TOGETHER:

To review the original 12-steps for alcoholics, log on to *Study Site Chapter 8*. In what ways is the original statement different from the woman's statement presented in Table 8.1?

Interactionist Perspective

Sociologists Edwin Sutherland and Howard Becker state that deviant behavior, such as drug abuse, is learned through others. Sutherland (1939) proposed the theory

of **differential association** to explain how we learn specific behaviors and norms from the groups we have contact with. Deviance, explained Sutherland, is learned from people who engage in deviant behavior. In his study, “Becoming a Marijuana User,” Becker (1963) demonstrated how a novice user is introduced to smoking marijuana by more experienced users. Learning is the key in Becker’s study:

No one becomes a user without (1) learning to smoke the drug in a way which will produce real effects; (2) learning to recognize the effects and connect them with drug use. . . ; and (3) learning to enjoy the sensations he perceives. (P. 58)

This perspective also addresses how individuals or groups are labeled “abusers” and how society responds to them. For example, consider alcohol abuse among the Native American population. Alcohol abuse and alcoholism are leading causes of mortality among American Indians, and there are disproportionately higher rates of alcohol-related crimes among American Indians. Yet, Holmes and Antell (2001) argue that alcohol abuse and its related problems are not entirely objective phenomena; they also involve interpretation and stigmatization of deviant behavior. One persistent societal myth maintains that as a group, American Indians have problems handling alcohol. However, research indicates that factors such as demography (a young population) and geography (rural Western environment) may explain high rates of alcohol-related problems in Indian populations.

The authors highlight the considerable variation in drinking patterns within and between tribal communities; in other words, not all American Indians have drinking problems. The social construction of the “drunken Indian” stereotype links alcohol abuse to the perceived “weaker” cultural and individual characteristics of American Indians. Holmes and Antell (2001) explain, “The persistence of such myths in the symbolic-moral universe of the dominant White culture, despite evidence to the contrary, suggests that alcohol use by American Indians still serves to document allegations of weak will and moral degeneracy” (p. 154). For a summary of the various sociological perspectives, see Table 8.2.

What Is Drug Abuse?

Drug abuse is the use of any drug or medication for a reason other than the one it was intended to serve or in a manner or in quantities other than directed, which can lead to clinically significant impairment or distress. **Drug addiction** refers to physical and/or psychological dependence on the drug or medication. Although many drugs can be abused, five drugs will be reviewed in the following section: alcohol, nicotine, marijuana, methamphetamine, and cocaine. Most of the information presented in this section is based on data from the National Institute on Drug Abuse [NIDA] and the ONDCP. For more information, log on to *Study Site Chapter 8*.

Alcohol

We may not consider it a drug, but alcohol is the most abused drug in the United States. Although the consumption of alcohol by itself is not a social problem, the

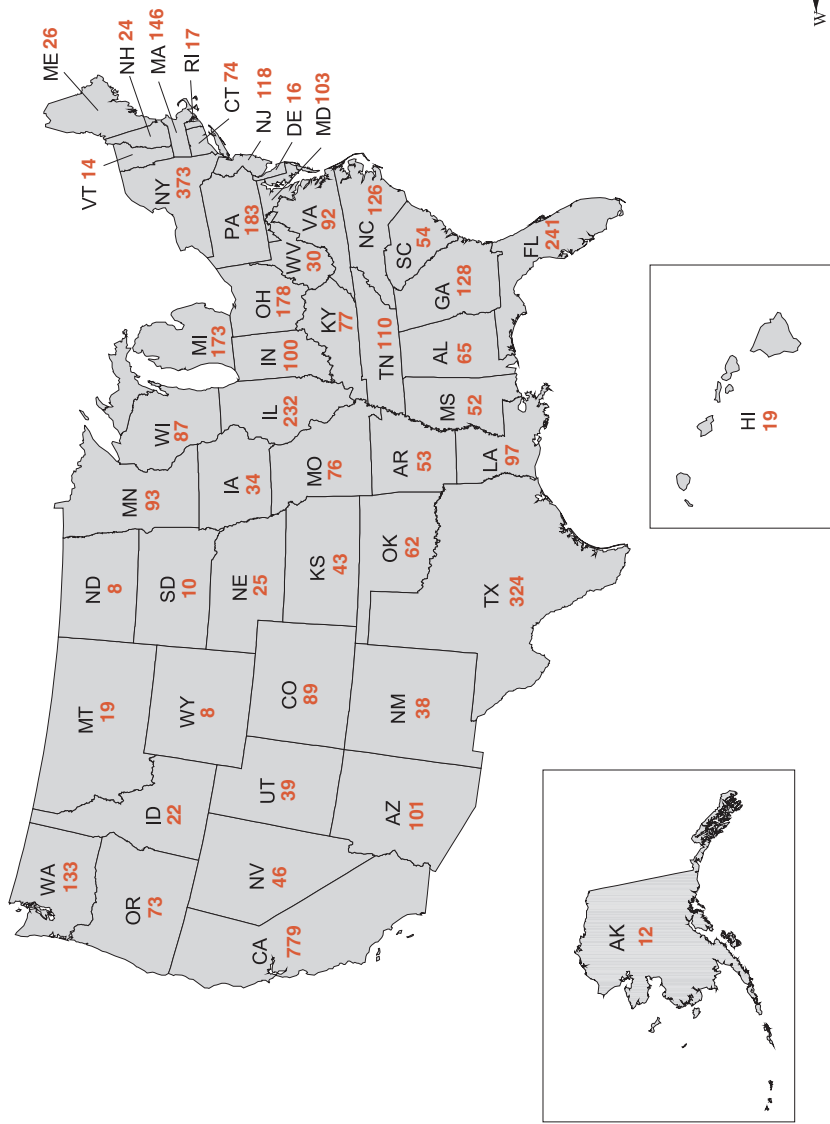
❖ **Table 8.2** Summary of Sociological Perspectives: Drug Abuse

	Functional	Conflict/Feminist	Interactionist
Explanation of drug abuse	Drug abuse is likely to occur when society is unable to control or regulate our behavior.	Powerful groups decide which drugs are illegal. Certain social groups are singled out for their drug abuse. There has been a lack of sensitivity to the range of drug abuse experiences.	Drug abuse is learned through interaction with others. The perspective also focuses on society's reaction to drug abuse, noting that certain individuals are more likely to be labeled as drug users than others.
Questions asked about drug abuse	What rules exist to control or encourage drug abuse? Are some groups or individuals more vulnerable to drug abuse than others?	What groups are able to enforce their definitions about the legality or illegality of drug use? How are they able to enforce their definitions? How are the experiences of women and minority drug users different from those of White males?	How is drug abuse learned through interaction? How are drug users labeled by society? Why are specific groups targeted?

continuous and excessive use of alcohol can become problematic. Four symptoms are associated with alcohol dependence or **alcoholism**: craving (a strong need to drink), loss of control (not being able to stop drinking once drinking begins), physical dependence (experiencing withdrawal symptoms), and tolerance (the need to drink greater amounts of alcohol to get “high”) (NIAAA 2003d).

Current drinking (12 or more drinks in the past year) and heavy drinking (five drinks on a single day at least once a month for adults) among adults is highest for American Indians and Alaska Natives, followed by Native Hawaiians. Prevalence of

U. S. DATA MAP 8.1



Estimated numbers (in thousands) of persons reporting any illicit drug dependence or abuse in 2001. Annual averages based on 2000 and 2001 National Household Survey on Drug Abuse. Source: SAMHSA, 2001.

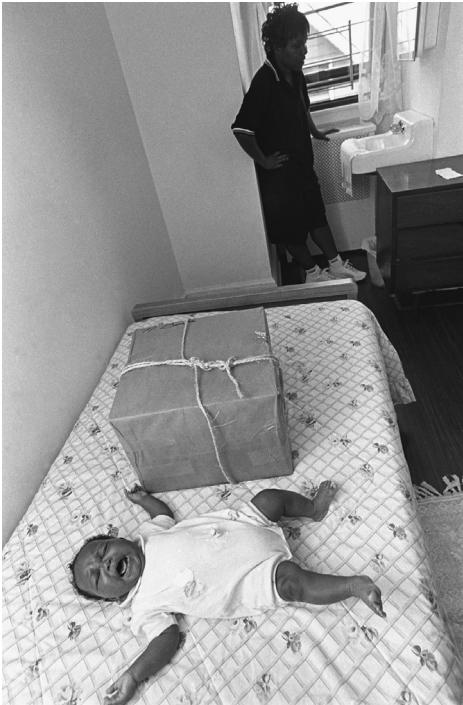
VISUAL ESSAY: DRUG LEGACY



Drug abuse is related to many social factors, including hopelessness, poverty, and violence. In her own Brooklyn neighborhood, photographer Brenda Ann Kenneally documented the legacy of drug abuse passed down from parent to child and its effects on their community. While his mom is taking a hit from her crack pipe, Andy “boxes” with the mailboxes in the hallway. The electricity for the family’s apartment has been turned off.

Kenneally also documents common violence and self-destructive behavior in her neighborhood. Fay, a crack dealer and user, tries to avoid being hurt by the man she sells crack for. She has smoked all the profits from her drug sales. She has also left her child with one of her customers, hiding him from authorities who would place him in foster care. Meanwhile, Lisa reveals the injury she inflicts on herself. Lisa has attempted many times, unsuccessfully, to quit using drugs; out of frustration she began cutting her left forearm with a knife.





The vicious cycle of drug abuse can be broken, however. One young woman, Moya, learned from her mother, Theresa, to be a cocaine smoker and dealer. Theresa spent eight years in recovery from her own addiction before dying of a weakened heart. At the time, Moya was out of prison on parole. Three weeks after the funeral, Moya was caught dealing again and sent back to prison. She bore a child while in prison but had to find a temporary home for her daughter while she finished her sentence. When released, all the resources Moya had to start over were her baby, named Theresa after her mother, and a single box of belongings.



Moya and Theresa found a temporary home in Hour Children, a convent-run support community. Hour Children operates five residences, offering a safe home environment for formerly incarcerated mothers and their children. As a condition of her stay, Moya is required to get a job or attend school. Perhaps baby Theresa's life may turn out differently from Moya's.

Which do you believe is more effective in breaking the cycle of drug abuse—punishment through incarceration or rehabilitation through community programs like Hour Children?

deaths from chronic liver disease and cirrhosis is about four times higher, and fatal car accidents due to alcohol three times higher, among American Indians and Alaska Natives than the rest of the U.S. population. Adult drinking is lowest among Asian Americans and Pacific Islanders, but alcohol use is increasing significantly in this group.

Among adolescent minorities, African Americans have the lowest rates of drinking and the lowest frequency of being drunk. Hispanic adolescents have the highest rates of heavy drinking, followed by White adolescents. Decline in alcohol abuse with increased age is called “aging out” or simply part of the maturation process. Although studies suggest that White adolescents drink alcohol more heavily and frequently than other ethnic/racial groups, White adolescents are also more likely to age out. During early to middle adulthood, the frequency of heavy drinking stabilizes among Whites, increases among African Americans, and declines but remains high for Hispanics (Caetano and Kaskutas 1995; Chen and Kandel 1995).

Alcohol researchers have begun to identify the importance of individual attributes, cultural factors, and structural factors in minority drinking. Studies suggest that ethnic/racial groups have different sets of norms and values regulating drinking. For example, some groups exhibit low rates of problem drinking because their culture associates the use of alcohol primarily with eating, social occasions, or rituals (Herd and Grube 1996). However, other ethnic/racial groups may consider drinking as an activity separate from eating or ritual celebrations, leading to higher rates of problem drinking. Researchers have also attributed alcoholism among ethnic minorities to three stressors: **acculturative stress**, experienced by most immigrants who are faced with leaving their homeland and adapting to a new country; **socioeconomic stress**, experienced by ethnic minorities who feel disempowered because of social and economic inequalities in U.S. society; and **minority stress**, which refers to the tension that minorities encounter due to racism (Caetano et al. 1998).

Research indicates that among all age and ethnic groups, men are more likely to drink than women and are more likely to consume large quantities of alcohol in a single sitting (NIAAA 2002). Although social class, occupational and social roles, and family history of alcohol all play a role in determining the drinking patterns of people in general, specific factors put women particularly at risk (Collins and McNair 2003). Research indicates that a woman’s risk for drinking increases with the experience of negative affective states, such as depression (Hesselbrock and Hesselbrock 1997) or loneliness, and negative life events, such as physical or sexual abuse during childhood or adulthood (Wilsnack et al. 1997). Other factors decrease women’s chances of developing alcohol problems. Traditionally, women are socialized to abstain from alcohol use or to drink less than men (Filmore et al. 1997). Women who do not participate in the labor force may have less access to alcohol than men (Wilsnack and Wilsnack 1992), and women’s roles as wife and mother may also discourage alcohol intake (Leonard and Rothbard 1999).

People who begin drinking before age 15 are four times more likely to develop alcohol dependence at some time in their lives compared to people who have their first drink at age 20 or older (NIAAA 2003c). O’Malley, Johnston, and Bachman (1998) report that adolescents who use alcohol are at higher risk for social, medical, and legal problems, such as poor school performance; interpersonal problems with friends,

❖ TAKING A WORLD VIEW



THE SCOTTISH DRINKING PROBLEM

Some have noted that “Scotland has a special relationship with alcohol” (Ritson 2002). Scotland is known for its Scotch whisky, a national beverage that is more than just a drink or a means of getting drunk. According to Sharon MacDonald (1994), whiskey is “a symbolic distillation of many images of Scottishness, especially hospitality, camaraderie, joviality, and masculinity” (p. 125).

Alcohol abuse in Scotland is increasing because of excessive drinking levels among adults and the frequency and level of drinking among teenagers. In recent studies, a third of Scots men (819,930) and 15 percent of women (394,487) between 16 and 64 years old were drinking more than the recommended weekly limits of less than 21 units for men and 14 units for women (a unit of alcohol is eight grams by weight) (Ritson 2002; Varney and Guest 2002). Younger age groups were more likely to exceed the weekly limits (Ritson 2002). It has been estimated that alcohol misuse costs Scottish society about 1,071 million pounds per year, the majority of the costs due to the criminal justice system, emergency services, losses of workplace productivity, and accidents (Varney and Guest 2002).

Men’s and women’s drinking are not viewed as equally problematic by Highland residents or the Scottish population in general. According to MacDonald (1994), in the

Highlands, although more men abuse alcohol, their drinking is viewed as a lesser problem than that of women who drink. Drunkenness is accepted, even expected, of Scottish males; but a drunken woman is considered unrespectable, slovenly, and loose. The drunk Scottish woman is a pathetic figure rather than the humorous figure of a drunk Scot male. It is likely, says MacDonald, that the number of women who abuse alcohol is underestimated due to the added stigma associated with women’s drinking. In her research, MacDonald was told of female alcoholics in “hushed, conspiratorial” tones. Women were desperate to conceal their drinking problem. Women’s drinking was more likely to be confined to home than men’s (MacDonald 1994).

In January 2002, the Scottish Executive launched a “Plan for Action on Alcohol Problems,” a national and local program aimed at reducing alcohol-related harm (Ritson 2002). The plan will focus on correcting harmful drinking patterns and influencing the habits of children and young people through prevention and education programs. The plan will also support and improve existing treatment services. The plan promises to achieve a “cultural change by an immediate investment [in] a national communication strategy that will challenge current stereotypes of binge drinking” (Ritson 2002:218).

family, and others; physical and psychological impairment; drunk driving; and death. The rate of fatal crashes related to alcohol among drivers ages 16 to 20 is more than twice the rate among drivers age 21 or older (NIAAA 2003c). The most common alcohol-related problem reported by adolescent drinkers is that alcohol use causes them to

behave in ways that they later regret (O'Malley et al. 1998). Underage use of alcohol is more likely to kill young people than all illegal drugs combined (NIAAA, 2003c).

Nicotine

Nicotine is the most frequently used addictive drug in the United States (NCADI 2003a), with cigarette smoking the most prevalent form of nicotine addiction. Nicotine is both a stimulant and a sedative to the central nervous system. An average cigarette contains about 10 milligrams of nicotine. Through inhaling the cigarette smoke, the smoker takes in 1 to 2 milligrams of nicotine per cigarette. Nearly 35 million users try to quit smoking per year, but it is estimated that less than 7 percent are able to achieve more than one year of abstinence (NIDA 1998).

About 66.5 million Americans reported current use of a tobacco product in 2001, about 29.5 percent of the population 12 years or older. The majority of tobacco users, about 56.3 million, reported smoking cigarettes (NCADI 2003a).

The prevalence of smoking is highest among Native Americans/Alaska Natives (40.9 percent), followed by African Americans and Whites (24.3 percent), Hispanics (18.1 percent), and Asians and Pacific Islanders (15.1 percent). It is estimated that 4.5 million teenagers are cigarette smokers; 22.4 percent of high school seniors smoke on a daily basis (American Lung Association 2002b).

Cigarette smoking is the most important preventable cause of cancer in the United States. It has been linked to 90 percent of all lung cancer cases and one third of all cancers. Smoking has also been linked to other lung diseases, such as chronic bronchitis and emphysema, and to cancers of the mouth, stomach, kidney, bladder, cervix, pancreas, and larynx. The overall death rates from cancer are twice as high among smokers as nonsmokers (NIDA 1998). It is estimated that 430,700 annual deaths are attributable to cigarette smoking (American Lung Association 2003b).

Passive or secondhand smoke is a major source of indoor air contaminants. Secondhand smoke is estimated to cause about 3,000 lung cancer deaths per year and may contribute to as many as 40,000 deaths related to cardiovascular disease (NIDA 1998). Exposure to cigarette smoking at home is harmful to children with asthma. The Environmental Protection Agency estimates that exposure to secondhand smoke may worsen the health of about 200,000 to 1 million asthmatic children (American Lung Association 2002a).

Despite the persistent public health message that smoking is bad for your health, smoking among teenagers has been on the rise since 1991 (Lewinsohn et al. 2000). In a study comparing adolescent smokers to nonsmokers, adolescent smokers were found to have more stressful environments, more academic problems, and poorer coping skills than nonsmokers. Adolescent smoking has also been associated with a number of environmental factors, such as disruptive home environment, parental and peer smoking, low social support from family and friends, conflict with parents, and stressful life events (Lewinsohn et al. 2000).

Data indicate that the use of smokeless chewing tobacco products (referred to as "snuff," "dip," or "chew") occurs at a significantly younger age than cigarette smoking. Smokeless tobacco products are consumed orally, with packets of the tobacco tucked

in a front lip or cheek. An average size chew kept in the mouth for 30 minutes provides the same amount of nicotine as three cigarettes (National Cancer Institute 2003). Smokeless tobacco may cause permanent gum recession, mouth sores, lesions, and cancers of the mouth and throat. Jones and Moberg (1988) examined smokeless tobacco use among adolescent males and discovered that regular use was related to being White, living in other than a two-parent home, performing poorly in school, smoking cigarettes, consuming alcohol, and engaging in delinquent behavior. Participation in team sports was associated with experimenting with smokeless products but not with regular use.

 **PUTTING IT TOGETHER:**
In your community.

The American Lung Association rates each state on smoke-free air ordinances, state laws limiting youth access to tobacco, state spending on tobacco prevention, and cigarette taxes. To determine your state's rating, go to *Study Site Chapter 8*.

Marijuana

Marijuana is the most commonly used illicit drug, widely used by adolescents and young adults (NIDA 2002a). The major active chemical in marijuana is THC or delta-9-tetrahydrocannabinol, which causes the mind-altering effects of the drug. THC is also the main active ingredient in oral medications used to treat nausea in chemotherapy patients and to stimulate appetite in AIDS patients (ONDCP 2003c).

Marijuana was used by 76 percent of the current illicit drug users, according to the National Household Survey on Drug Abuse 2001 (ONDCP 2003c). More than 83 million Americans (or 37 percent) age 12 or older have tried marijuana at least once in their lifetime (NIDA 2002a). According to the Centers for Disease Control, 42.4 percent of surveyed high school students have used marijuana in their lifetime. Male students (46.5 percent) were more likely to report lifetime marijuana use than female students (38.4 percent) (ONDCP 2003c). Longitudinal data show increases in marijuana use during the 1960s and 1970s, declines in the 1980s, with increasing use since the 1990s (NIDA 2002a).

Acute marijuana use can impair short-term memory, judgment, and other cognitive functions as well as a person's coordination and balance, and it can increase heart rate. Chronic abuse of the drug can lead to addiction, as well as increased risk of chronic cough, bronchitis, or emphysema. Addictive use of the drug may interfere with family, school, or work activities. Smoking marijuana increases the risk of lung cancer and cancer in other parts of the respiratory tract more than smoking tobacco does (NIDA 2002a). Marijuana smoke contains 50 percent to 70 percent more carcinogenic hydrocarbons than tobacco smoke (ONDCP 2003c). Because marijuana users inhale more deeply and hold their breath longer than cigarette smokers do, they are exposed to more carcinogenic smoke than cigarette smokers. In 2001, marijuana use was a contributing factor in more than 110,000 emergency room visits. About 15 percent of these patients were between 12 and 17 years of age, and almost two thirds were male (NIDA 2002a).

Methamphetamine

Methamphetamine or “meth” is a highly addictive central nervous system stimulant that can be injected, snorted, smoked, or ingested orally. A derivative of amphetamine, methamphetamine was therapeutically used in the 1930s to treat asthma and narcolepsy (sleeping disorder) (Pennell et al. 1999). It is the most prevalent synthetic drug manufactured in the United States. The increase in methamphetamine use has been attributed to the ease of manufacturing the drug and to its highly addictive nature (ONDCP 2003d). The drug is commonly referred to as “speed,” “crystal,” “crank,” “go,” and “ice” (a smokable form).

More than 9 million people have tried methamphetamine at least once in their lifetime (ONDCP 2003d). The highest rate of use is in the 18 to 25 age group. Meth is concentrated in the rural and Western areas of the United States, but it has spread throughout every major metropolitan area, except in the Northeast. Among high school students, male students (10.5 percent) are more likely to report methamphetamine use than female students (9.2 percent). White students (11.4 percent) are more likely than Hispanic (9.1 percent) or Black (2.1 percent) students to have used the drug.

Chronic methamphetamine use can cause violent behavior, anxiety, confusion, and insomnia. Users may also exhibit psychotic delusions, including homicidal or suicidal thoughts. Long-term use of the drug can lead to brain damage, similar to damage associated with Alzheimer’s disease, stroke, or epilepsy (ONDCP 2003d).

Cocaine

Cocaine is one of the oldest known drugs, derived from the leaves of the coca bush. Cocaine is listed as a Schedule II drug, a drug with a high potential for abuse. The drug is a strong central nervous system stimulant and can be snorted, smoked, or injected. Crack is the street name for cocaine that has been processed from cocaine hydrochloride into a smokable substance. Because crack is smoked, the user experiences a high in less than 10 seconds.

In 2002, 2 million Americans were current cocaine users. Adults 18 to 25 years old have a higher rate of use than any other age group. Overall, men have higher rates of use than women. Rates of cocaine use are higher for American Indians/Alaska Natives (2.0 percent) and African Americans (1.6 percent) than for Hispanics (0.8 percent) and Whites (0.8 percent). Cocaine initiation is more likely to occur among adults rather than youths under 18. In 1968, the average age of a new user was 18.6 years; it was 23.8 years in 1990 and 21 years from 1995 to 2001 (SAMHSA 2003c).

Some of the most common complications of the drug include cardiovascular disease (disturbances in heart rhythm and heart attacks), respiratory effects (chest pain and respiratory failure), neurological effects (strokes, seizures), and gastrointestinal complications (NIDA 2002b).

The full effect of prenatal drug exposure is not completely known. Babies born to mothers who abuse cocaine are often premature, have low birth weights, and are often shorter in length. It has been predicted that “crack babies” will suffer severe irreversible damage. However, it appears that most crack babies recover, although there is indication of some learning deficits, such as the child’s inability to block distractions or to concentrate for long periods of time (NIDA 2002c).

The Problems of Drug Abuse

Drug Abuse and the Relationship with Crime and Violence

Drinking- and alcohol-related problems have been associated with intimate partner violence among White, Black, and Hispanic couples. This does not mean that violence can only occur when drinking is involved or that alcohol is the prime cause of the violence. Rather some people may consciously use alcohol as an excuse for violent behavior. Also, alcohol may be related to violence because heavier drinking and violence have common predictors, such as impulsive personalities (Caetano, Schafer, and Cunradi 2001).

Alcohol use has also been associated with child abuse as both a cause and a consequence (Widom and Hiller-Sturmhofel 2001). Parental alcohol abuse may increase a child's risk of experiencing physical or sexual abuse, either by a family member or another person. Parental alcohol abuse may also lead to child neglect. Studies indicate that girls who were abused or neglected are more likely to have alcohol problems as adults than other women (Widom and Hiller-Sturmhofel 2001).

National Crime Victim Surveys indicate that the rate of alcohol-involved violent crimes (crimes in which the offender has been drinking, as perceived by victims) has decreased 34 percent from 1993 to 1998, a shift from 2.1 million incidents in 1993 to 1.4 million in 1998. Alcohol abuse is more often suspected in crimes than abuse of any other drug. However, the number of violent offenses in which the offender was believed to be using other drugs (illicit drugs) increased 19 percent during the same time period (443,426 in 1993 to 526,522 in 1998). For 1998, 41 percent of probationers, 41 percent of jail inmates, 38 percent of state prisoners, and 20 percent of federal prisoners reported that they were drinking at the time of the offenses for which they were convicted. Nearly one half of the violent victimizations that involved alcohol occurred in a residence, with more than 20 percent occurring in the victim's home. About one third of the alcohol-involved victimizations resulted in an injury to a victim. It has been estimated that the loss per victim of alcohol-involved violence was about \$1,016 or an estimated annual loss of \$400 million per year (Greenfeld and Henneberg 2001).

Drug Abuse and the Impact on Work

Employers have always been concerned about the impact of substance abuse on their workers and their businesses. According to the U.S. Department of Labor, although the rate of current illicit drug use is higher among unemployed people, about 73 percent of drug users or 8.1 million people are employed, costing businesses billions of dollars annually in lost productivity and health care costs (U.S. Department of Labor 2003). It is estimated that drug abuse cost American businesses \$81 billion in lost productivity, \$37 billion due to premature death, and \$44 billion due to illness in 2002. Alcohol abuse contributed to about 86 percent of the costs (U.S. Department of Labor 2003b).

In their examination of occupational risk factors for drug abuse, MacDonald, Wells, and Wild (1999) found that problem drinking or drug use was linked to the quality and organization of work, drinking subcultures at work, and the safety of the workplace. Respondents reporting alcohol problems were more likely to have jobs involving repetitive tasks and dangerous working conditions. Respondents with

alcohol problems were also more likely to drink with coworkers and experience some social pressure to drink. The same pattern was also true for workers with drug problems: They considered their jobs “boring” or repetitive; they identified their job as dangerous; they experienced stress at work; or they were likely to be part of a drinking subculture at work. Among all factors they identified, the presence of a drinking subculture at work was the strongest risk factor for alcohol and drug abuse.

By occupation, the highest rates of current illicit drug use and heavy drinking were reported by food preparation workers, waiters/waitresses, and bartenders (19 percent); construction workers (14 percent); service occupations (13 percent); and transportation and material moving workers (10 percent) (U.S. Department of Labor 2003b).

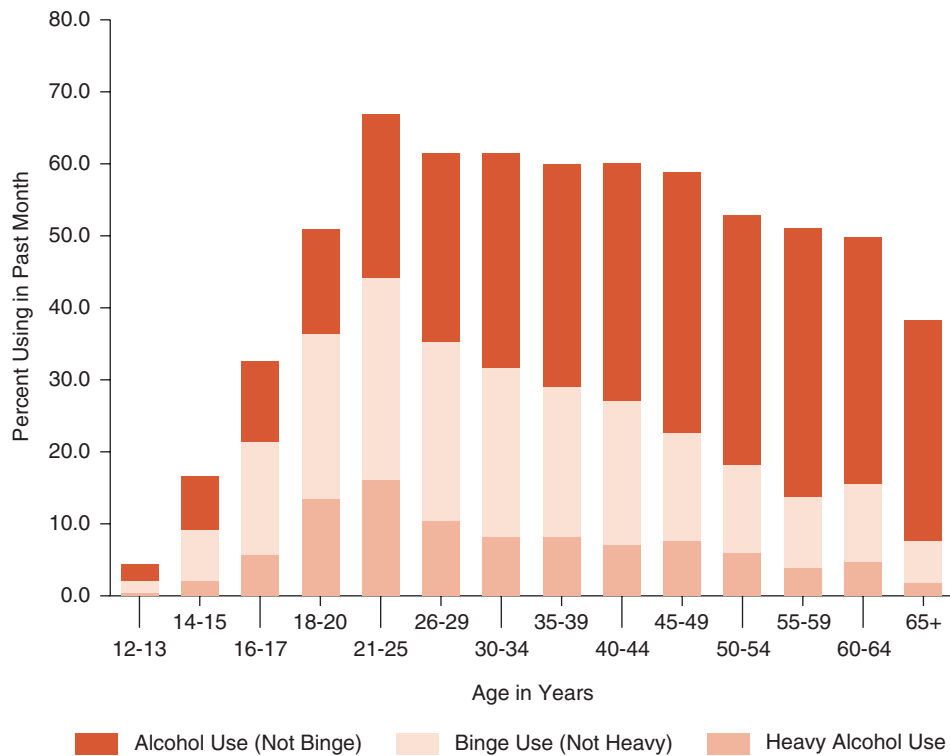
Among employed adults, White, non-Hispanic males between the ages of 18 and 25 who have less than a high school education are likely to report the highest rates of heavy drinking and illicit drug use (U.S. Department of Labor 2003b).

Problem Drinking among Teens and Young Adults

Binge drinking is defined as drinking five or more drinks within a few hours (or within one sitting). For 2002, the National Survey on Drug Use and Health (NSDUH) reported that about 54 million people (or 22.9 percent) ages 12 to 20 participated in binge drinking at least once in the 30 days prior to the survey. In 2002, the highest prevalence of binge and heavy drinking (five or more drinks on the same occasion on at least five different days in the past 30 days) was for young adults ages 18 to 25, with the peak rate occurring at age 21. Heavy drinking was reported by 14.9 percent of people 18 to 25 and by 20.1 percent of people age 21. Binge and heavy drinking were lowest for people age 65 or older, with reported rates of 7.5 percent and 1.4 percent respectively (SAMHSA 2003c). See Figure 8.1 for a summary of 2002.

Binge drinking among college students has been called a major public health concern (Clapp, Shillington, and Segars 2000). Henry Wechsler (1996) reported results from the 1996 Harvard School of Public Health College Alcohol Study, highlighting how binge drinking has become widespread among college students. In the Wechsler study, binge drinking was defined as five or more drinks in a row one or more times during a two-week period for men and four or more drinks in a row one or more times during a two-week period for women. The author explains how men, students under 24, fraternity and sorority residents, Whites, students in athletics, and students who socialize more are most likely to binge drink. On average, students who engaged in high-risk behaviors such as illicit drug use, unsafe sexual activity, and cigarette smoking were more likely to be binge drinkers. In contrast, students who were involved in community service, the arts, or studying were less likely to be binge drinkers (Wechsler 1996). Access to alcohol is also related to problem drinking. Weitzman et al. (2003) reported a positive relationship between alcohol outlet density (number of bars, liquor stores near campus) and frequent drinking (drinking on 10 or more occasions in the past 30 days), heavy drinking (five or more drinks at an off-campus party) and drinking problems (self-reported).

The Task Force of the National Advisory Council on Alcohol Abuse and Alcoholism (2002) concluded that 1,400 college students between the ages of 18 and

❖ **Figure 8.1** Past Month Alcohol Use by Age: 2002

Source: Substance Abuse and Mental Health Services Administration. 2003c.

24 die each year from alcohol-related unintentional injuries, including motor vehicle crashes. About half a million students between the ages of 18 and 24 are unintentionally injured while under the influence of alcohol, and more than 600,000 students are assaulted by another student who has been drinking. In addition the Task Force reports that 25 percent of college students report academic consequences (poor grades, poor performance, missing classes) as a result of their drinking, and more than 150,000 develop an alcohol-related health problem. Based on self-reports about their drinking, 31 percent of college students met the criteria for alcohol abuse, and 6 percent met the criteria for alcohol dependence (Task Force of the National Advisory Council on Alcohol Abuse and Alcoholism 2002).

Brower (2002) explains that there is no evidence that drinking in college leads to later-life alcoholism or long-term alcohol abuse. He writes, "Real life is a strong disincentive for the kind of binge drinking that college students do" (p. 255). He suggests using the term *episodic high-risk drinking* to describe more accurately how college students drink: infrequently drinking a large quantity of alcohol in a short period of time.

By the time they reach the eighth grade, nearly 50 percent of adolescents report having had at least one drink, and more than 20 percent report having been drunk (NIAAA 2003d). Underage drinkers account for nearly 20 percent of the alcohol consumed in the United States (Tanner 2003). In 2001, among youth ages 12 to 17, 17.3 percent used alcohol in the month prior to the National Household Survey on Drug Use, higher than the rate of youth alcohol use reported in 2000, 16.4 percent. Among all youth, 10.6 percent were binge drinkers, and 2.5 percent were heavy drinkers, no increase from the 2000 figures (SAMHSA 2003c).



PUTTING IT TOGETHER: On your campus.

What is the drinking policy on your campus? What educational or service programs are provided for students who abuse alcohol?

The Increase in Club Drugs

MDMA (3–4 methylenedioxymethamphetamine) is a synthetic psychoactive drug with stimulant and hallucinogenic properties. The pill—popularly known as Ecstasy, Adam, X, XTC, hug, beans, and love drug—first gained popularity at dance clubs, raves, and college scenes. The 1998 National Household Survey on Drug Abuse reported that 1.5 percent or 3.4 million Americans have used MDMA at least once during their lifetime. The heaviest use was among 18 to 25 year olds, about 5 percent or 1.4 million in this age group (NIDA 2003c). MDMA is usually taken in pill form at the cost of about \$25 per tablet, but the drug can also be snorted, injected, or used in a suppository.

Rohypnol, GHB, and Ketamine are other drugs commonly used in club and rave scenes. All three are also known as “date rape” drugs. Previously confined to club or rave subculture, Ecstasy has become a mainstream drug (NIDA 2003c), second only to marijuana as the most frequently used illicit drug among young adults (Johnston, O’Malley, and Bachman 2001).

From 2002 to 2004, a public service announcement sponsored by the Partnership for a Drug Free America featured Jim and Elsa Heird. The Nevada couple’s 21-year-old daughter, Danielle, took Ecstasy on three occasions; the last time it resulted in her death. After taking one or one and a half pills, Danielle began to feel ill and decided to stay home to rest. A few hours later when her friends came home, they found her dead. There were no other controlled substances or alcohol in her body at the time of her death (Vaughn 2002). Ecstasy-related deaths like Danielle Heird’s are rare. In 1999, there were 13 Ecstasy-related deaths, 8 in Miami, Florida, and 5 in Minneapolis/St. Paul, Minnesota (NIDA 2003c).

Even when they are not fatal, Ecstasy and other related drugs, known collectively as methylated amphetamines, are not harmless drugs. Ecstasy produces an intense release of serotonin in a user’s brain, which can cause irreparable damage to the brain and memory functions. Research indicates that long-term brain damage, especially to the parts of the brain critical to thought and memory, may result from its use. Users may also experience psychological difficulties (such as confusion, depression, and sleeping problems) while using the drug and sometimes for weeks after. As a result

of using the drugs, individuals can also experience increases in heart rate and blood pressure and physical symptoms such as nausea, blurred vision, or faintness (NIDA 2003c). When users overdose, they can experience rapid heartbeat, high blood pressure, faintness, panic attacks, and even loss of consciousness (Vaughn 2002).

In a study of undergraduates at a large Midwestern university, Boyd, McCabe, and d'Arcy (2003) found that men and women were equally likely to have used Ecstasy, and several factors predicted its use. White students were more likely to report lifetime Ecstasy use than African American or Asian students. According to the researchers, sexual orientation was also related to Ecstasy use: Those who identified themselves as gay, lesbian, or bisexual were more likely to report lifetime, annual, or past month Ecstasy use than heterosexual students. Students with a GPA of 3.5 or higher were consistently less likely to have used Ecstasy in the past year or their lifetime than students with GPAs below 2.5. Students who reported binge drinking within the past two weeks were also more likely to report past-month Ecstasy use.

Do You Have a Meth Lab Next Door?

In the early 1990s, the primary sources of methamphetamines were super laboratories in California and Mexico. Super labs are able to produce 10 pounds of meth in a 24-hour production cycle. In 2001, 298 super labs were raided by enforcement officials. Authorities seized 1,370 kilograms of meth along the U.S.-Mexico border in 2001, compared with only 6.5 kilograms in 1992. At the same time, there has been an increase in the number of small-scale labs operated by independent “cooks.” Meth produced in these labs is primarily for personal use or limited distribution. In 2001, the number of labs with capacities under 10 pounds totaled more than 7,000, by one estimate (Drug Enforcement Administration 2003).

Certain aspects of the manufacturing and use of methamphetamines, compared to other illegal drugs, have different consequences. Unlike other drugs, meth is easy to make with common chemicals that are easy to obtain (Pennell et al. 1999). The drug can be manufactured illicitly in laboratories set up in homes, motels, trailers, cars, or public storage lockers. Of the 32 chemicals that are used to make or “cook” meth, about one third of the chemicals are toxic (Snell 2001). The waste and residue remaining from meth cooking can contaminate water supplies, soil, and air, causing danger to people, animals, and plant life in the area. Many of the chemicals are explosive, flammable, and corrosive. Among the 1,654 labs seized in 1998, nearly one in five were found because of fire or explosion (Snell 2001). Nationally, meth labs caused more than 200 fires and explosions in 2003 (Johnson 2004).

Sandra Rupert, an elementary school counselor in Boone, North Carolina, was worried about two sisters who were second and third graders. The sisters had headaches, colds, and coughs nearly every day. When the Sheriff's Department raided the children's home, a meth lab was discovered in the room next to where the sisters slept. The girls were suffering from toxic fumes emitted by the chemicals. They were removed immediately from the home and the custody of their mother (Butterfield 2004). For every pound of meth that is produced, five to six pounds of highly toxic

waste are generated (Pennell et al. 1999; Snell 2001). Cleanup is very dangerous; law enforcement officers must wear hermetically sealed suits and self-contained breathing apparatuses for protection. Cleanup costs of large meth labs can exceed \$100,000 (Snell 2001).

Once cooking locations are discovered, they often have to be stripped, fumigated, or destroyed before the site can be safely lived in again, but there is no guarantee that complete cleanup will be possible. The North Carolina sisters had to leave all their belongings, toys, and clothing when they were removed from their mother's home. The consequences of methamphetamine use and production present serious challenges to law enforcement, policymakers, and the public (Pennell et al. 1999). Drug and law enforcement agencies have created public educational materials informing the public of what to look for if a meth lab is suspected in their neighborhood (refer to Table 8.3).

❖ Table 8.3 Is There a Meth Lab in Your Neighborhood?

Meth causes health problems not only for its users, but also for those unintentionally exposed to meth and to the chemicals used to make it. Even brief exposure to high levels of the chemicals found in meth labs may cause shortness of breath, chest pain, lack of coordination, and possibly even death. Illegal meth labs can be set up in homes, rest areas, rental properties, abandoned cars, and vacant buildings.

Here are some things you should look out for in your neighborhood:

- Unusual strong odors (like cat urine, ether, ammonia, acetone, or other chemicals)
- Residences with windows blacked out
- Renters who pay their landlords in cash
- Lots of traffic, with people coming and going at unusual times; little traffic during the day, but dramatically increased activity at night
- Excessive trash including large amounts of items such as antifreeze containers, lantern fuel cans, red chemically stained coffee filters, drain cleaner, and duct tape
- Unusual numbers of clear glass containers being brought into the home

The presence of the following items could also indicate the existence of a meth lab:

- Alcohol
- Paint thinner
- Gasoline/kerosene/camp stove fuel
- Drain cleaner (sulfuric acid)
- Epsom salts
- Batteries/lithium
- Propane cylinders (20 lbs)
- Hot plates
- Cold tablets (Ephedrine or Pseudophedrine)

Do not enter a site or handle materials you think may be used for cooking meth. Immediately contact local law enforcement.

Source: KCI 2003.

Drug Advocacy, Innovation, and Policy

Federal Programs

Throughout the first part of this chapter, I have already referred to three offices: the NIDA, the ONDCP, and the NIAAA. All three programs are federally funded.

The NIAAA was established after the passage of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970. Signed into law by President Richard Nixon, the legislation acknowledged alcohol abuse and alcoholism as major public health concerns. The law instructed the NIAAA to “develop and conduct comprehensive health, education, research, and planning programs for the prevention and treatment of alcohol abuse and alcoholism and for the rehabilitation of alcohol abusers and alcoholics” (NIAAA 2003a). Since then, the NIAAA’s mission has been revised to include support and implementation of biomedical and behavioral research, policy studies, and research in a range of scientific areas to address the causes, consequences, treatment, and prevention of alcoholism and alcohol-related problems (NIAAA 2003b).

NIDA was established in 1974 as the federal office for research, treatment, prevention, training services, and data collection on the nature and extent of drug abuse. Like NIAAA, NIDA is part of the National Institutes of Health, the federal biomedical and behavioral research agency. NIDA’s stated mission is to bring “the power of science to bear on drug abuse and addiction” (NIDA 2003a). NIDA supports more than 85 percent of the world’s research on the health aspects of drug abuse and addiction.

The ONDCP is the newest federal drug program. Established in 1988 through the Anti-Drug Abuse Act, the ONDCP’s mission was to set national priorities, design comprehensive research-based strategies, and certify federal drug control budgets. According to the Act, the purpose of the Office was to prevent young people from using illegal drugs, reduce the number of drug users, and decrease the availability of drugs (ONDCP 2003b). Ten years later, ONDCP’s mission was expanded under the Reauthorization Act of 1998. Some of the legislative requirements included a commitment to a five-year national drug control program budget, the establishment of a parents’ advisory council on drug abuse, development of a long-term national drug strategy, and increased reporting to Congress on drug control activities (ONDCP 2003b). The Act also provided support for the High Intensity Drug Trafficking Areas (HIDTA) program, coordinating local, state, and federal law enforcement drug control efforts.



PUTTING IT TOGETHER: On the Web.

You can visit the HIDTA Web site by logging on to the *Study Site Chapter 8*. On the state map, click on the location nearest to your college. Not all states have been identified as including a HIDTA. The link should take you to regional or state HIDTA program information, including a description of the extent of drug trafficking in the area, along with a list of participating agencies and significant achievements in the fight against drug trafficking.

Extensive use of illegal drugs continues despite the efforts of these three lead agencies. The War on Drugs comes with huge economic cost, \$19.2 billion in 2003, paid directly to the ONDCP (2003a). Although most advocates support prevention and law enforcement efforts, some have attempted to explore alternative strategies to the problem of drug abuse.

Drug Legalization

The contemporary debate about the legalization of drugs emerged in 1988 during a meeting of the U.S. Conference of Mayors. Baltimore's Kurt L. Schmoke called for a national debate on drug control policies and the potential benefits of legalizing marijuana and other illicit substances (Inciardi 1999). Proponents present several arguments for the legalization of drugs: Current drug laws and law enforcement initiatives have failed to eradicate the drug problem; arresting and incarcerating individuals for drug offenses does nothing to alleviate the drug problem; drug crimes are actually victimless crimes; legalization will lead to a reduction in drug-related crimes and violence and improve the quality of life in inner cities; and legalization will also eliminate serious health risks by providing clean and high-quality substances (Cussen and Block 2000; Silbering 2001). Many supporters of legalization argue that drugs should be legalized based on the libertarian legal code (Trevino and Richard 2002), namely that the legalization of drugs would give a basic civil liberty back to citizens by granting them control over their own bodies (Cussen and Block 2000).

The term **legalization** is often used interchangeably with another term, **decriminalization**. The terms vary in terms of the extent to which the law can regulate the distribution and consumption of drugs. In general, decriminalization means keeping criminal penalties but reducing their severity or removing some kinds of behavior from inclusion under the law (e.g., eliminating bans on the use of drug paraphernalia). Some would support regulating drugs in the same way alcohol and tobacco are regulated, whereas others would argue for no restrictions at all. Legalization suggests removing drugs from the control of the law entirely (Weisheit and Johnson 1992).

Drug legalization is generally opposed by the medical and public health community (Trevino and Richard 2002). The American Medical Association has consistently opposed the legalization of all illegal drugs, arguing that most research shows drugs, particularly cocaine, heroin, and methamphetamines, are harmful to an individual's health. Opponents charge that drug use is a significant factor in the spread of sexually transmitted diseases such as HIV, and drug users are more likely to engage in risky behaviors and in criminal activity (Trevino and Richard 2002). The Drug Enforcement Administration has also been clear about its opposition to drug legalization, citing concerns over potential increases in drug use and addiction, drug-related crimes, and costs related to drug treatment and criminal justice.

In the 1990s, the drug debate began to change, with legalization proponents advocating a "harm reduction" approach. Many opposed to legalization began to accept aspects of the harm reduction approach. Harm reduction is a principle suggesting that "managing drug misuse is more appropriate than attempting to stop it all together" (Inciardi 1999:3). Proponents acknowledge that current drug policies are not working, but they are still not in favor of full decriminalization (McBride, Terry, and Inciardi

1999). The harm reduction approach emphasizes treatment, rehabilitation, and education (McBride et al. 1999), including advocacy for changes in drug policies (such as legalization), HIV/AIDS-related interventions, broader drug treatment options, counseling and clinical case management for those who wish to continue using drugs, and ancillary interventions (housing, healing centers, advocacy groups) (Inciardi 1999).

**PUTTING IT TOGETHER:**
On the Web.

The Drug Policy Alliance (2003a) is an organization “working to broaden the public debate on drug policy and to promote the realistic alternatives to the war on drugs based on science, compassion, health, and human rights.” Since 1996, 40 states have enacted more than 100 drug policy reforms. The reforms usually target drug sentencing and the legalization of medical marijuana. For more information on drug policies in your state, go to *Study Site Chapter 8*.

Punishment or Treatment?

Stricter federal policies have increased the number of men and women serving jail or prison time for drug-related offenses. As conflict and symbolic interaction theories suggest, drug laws are not enforced equally, with certain minority groups being singled out. Although most illicit drug users are White, Blacks constitute about 80 percent to 90 percent of all people sent to prison on drug charges. Nationwide, Black men are sent to state prison on drug charges at 13 times the rate of White men (Fellner 2000). Drug enforcement usually targets urban and poor neighborhoods while ignoring drug use among middle- or upper-class people. Whereas our society treats middle- or upper-class drug use as a personal crisis (consider, for example, that despite talk show host Rush Limbaugh’s 2003 rehabilitation for prescription drug addiction, he was never charged for illegal drug use and doctor shopping for painkillers), lower-class drug use is defined as criminal. However, in 2004, John P. Walters, director of the White House’s ONDCP, announced the first comprehensive plan to attack prescription drug abuse, “an increasingly widespread and serious problem in this country.” The program would monitor patients suspected of doctor shopping, would detect suspicious prescriptions, and would track illegal Internet sales (ONDCP 2004).

Sasha Abramsky (2003) explains that with tougher drug laws, the drug war was taken away from the public health and medical officials and placed into the hands of law enforcement and courts. The notion that drug abuse is a disease was replaced with the idea that drug abuse is a crime. However, as overall crime rates began to decline, public support for the get-tough-on-drugs policy began to wane. Research conducted by the Pew Research Center in 2001 found that 73 percent of Americans favored permitting medical marijuana prescriptions, 47 percent favored rolling back mandatory minimum sentences for nonviolent drug offenders, and 52 percent believed drug use should be treated as a disease rather than as a crime. Although federal policy seems unlikely to change in the near future, several states are reexamining the way they deal with drug offenders.

Abramsky (2003) recognizes key legislative changes in several states. Arizona and California passed recent legislation that diverted thousands of drug offenders into treatment programs instead of prisons. In 1998, Michigan repealed its mandatory life sentence law for those caught in the possession of more than 650 grams of certain narcotics. In 2002, Michigan Governor John Engler signed legislation that rolled back the state's tough mandatory-minimum drug sentences. The Kansas Sentencing Commission proposed reforms of the state's mandatory sentencing codes, along with expansion of treatment programs. The reforms were accepted in March 2003. Abramsky (2003) explains, "Increasingly impatient with the costly combination of policing and prosecution, voters, along with a growing number of state and local elected officials, have abandoned their support for incarceration-based anti-drug strategies and have forced significant policy shifts" (p. 26).

Drug Treatment and Prevention Programs

Individual Approaches

Drug addiction is a "treatable disorder" (NIDA 2003b). Traditional treatment programs focus on treating the individual and his or her addiction. The ultimate goal of treatment is to enable users to achieve lasting abstinence from the drug, but the immediate treatment goals are to reduce drug use, improve the user's ability to function, and minimize their medical and social complications due to drug use.

Treatment may come in two forms: Behavioral treatment includes counseling, support groups, family therapy, or psychotherapy; medication therapy, such as maintenance treatment for heroin addicts, may be used to suppress drug withdrawal symptoms and craving. Short-term treatment programs can include residential treatment, medication therapy, or drug-free outpatient therapy. Long-term programs (longer than six months) may include highly structured residential therapeutic community treatment or, in the case of heroin users, methadone maintenance outpatient treatment. Over the past 25 years, research indicates that treatment does work to reduce drug intake and drug-related crimes. Patients who stay in treatment longer than three months have better outcomes than people who undergo shorter treatment (NIDA 2003b).

Workplace Strategies

Certain employers, such as employers in the transportation industry or organizations with federal contracts in excess of \$100,000, are required by law to have drug-free workplace programs. The federal government, through the Drug Free Workplace Program, also encourages private employers to implement such programs in an effort to reduce and eliminate the negative effects of alcohol and drug use at the workplace (SAMHSA 2003b). The American Management Association reported that the percentage of companies that test employees for drugs increased from 22 percent in 1987 to more than 81 percent in 1997 (Hoffman and Larison 1999). After implementing a drug-free workplace program, employers, unions, and employees are likely to see a decrease in administrative work losses (sick leave abuse, health insurance claims, disability payments, and accident costs), hidden losses (poor performance, material waste, turnover, and premature death), legal losses (grievances, threat to public safety,

worksite security) and costs of health and mental health care services (SAMHSA 2003a).

Drug-testing programs have been subject to lawsuits over the past decade for challenging the employees' right to privacy and their constitutional freedom from unreasonable searches by the government (SAMHSA 2003b). There have also been challenges to the accuracy of drug tests. Critics have asserted a positive test does not always correlate with poor job performance, a criterion for assessing the adverse effects of drugs (Klingner, Roberts, and Patterson 1998). Consistent with conflict theories on drug use, some have argued that drug testing promotes various political agendas and reflects the manipulation of interest groups that market and sell drug testing and security services (Klingner et al. 1998). Yet, many U.S. companies consider drug-testing programs part of an effective policy against substance abuse among workers (Hoffman and Larison 1999).

Roman and Blum (2002) report that employee assistance programs (or EAPs) are the most common intervention used in the workplace to prevent and treat alcohol and other drug abuse among employees. The primary goal for many of these programs is to ensure that employees maintain their employment, productivity, and careers. These EAPs usually include health promotion, education, and referral to abuse treatment as needed. Most of these programs do not target the general workplace population; rather, services are directed to those already affected by a problem or in the early stages of their abuse. There is some evidence of the effectiveness of these programs, returning substantial proportions of employees with alcohol problems to their jobs (Roman and Blum 2002).

Campus Programs

The U.S. Supreme Court ruled that drug testing in schools is legal for student athletes (1993) and for students in other extracurricular activities (2002). In both rulings, the Court stated that drug screenings play an important role in deterring student drug use.

However, a national study of 76,000 high school students reported no significant difference between drug use among students in schools with testing versus students in schools without testing. Researchers Yamaguchi, Johnston, and O'Malley (2003) reported that 37 percent of 12th graders in schools that test for drugs said that they had smoked marijuana in the previous year, compared to 36 percent of 12th graders in schools that did not test. In addition 21 percent of 12th graders in schools with testing reported that they had used illicit drugs (cocaine or heroin) in the previous year compared with 19 percent of 12th graders in schools without drug screenings. The study found that only 18 percent of schools did any kind of drug screening between 1998 and 2001. Large schools (22.6 percent) reported more testing than smaller schools (14.2 percent). The majority of drug tests were conducted in high schools. The study did not compare schools that conducted intensive regular screenings with those that occasionally tested for drugs. The study indicated that education, not testing, may be the most effective weapon against abuse (Winter 2003).

In their review of 94 college drug prevention programs, Andris Ziemelis, Ronald Buckman, and Abdulaziz Elfessi (2002) identified three prevention models that produced the most favorable outcomes in binge-drinking prevention efforts. The first model includes student participation and involvement, such as volunteer services,

advisory boards, or task forces to discourage alcohol or other drug use or abuse. The researchers documented how these activities serve to reinforce students' beliefs that they are in control of the outcomes in their lives and that their efforts and contributions are valued. This model encourages student ownership and development of the program. The second model includes educational and informational processes, such as instruction in classes, bulletin boards and displays, and resource centers. The most effective informational strategies were those that avoided coercive approaches but instead encouraged interactive communication between students and professionals on campus. The last model includes efforts directed at the larger structural environment, changing the campus regulatory environment and developing free alternative programming, such as providing alcohol-free residence halls or mandatory alcohol and drug abuse classes as part of campus intervention. In general, models that discourage or deglamorize alcohol and drug use were associated with better outcomes than those that merely banned or restricted substance use (Ziemelis et al. 2002).

❖ **Voices in the Community:** *Jill Ingram*

This article about Jill Ingram, of the National College Commission of Mothers Against Drunk Driving (MADD), was taken from MADD's Web site (Glenn 2000).

... Ingram became involved in underage drinking prevention after her brother was hit by a drunk driver in 1996.

Ingram's brother, Dan, and his date were on their way home from a college sorority formal when the drunk driver—who [was] driving her van, headlights off, on the wrong side of a divided highway—hit their car head-on. Dan sustained multiple injuries to his ankle, knee, and wrist in the crash.

"There were several witnesses who saw [the drunk driver] and honked to get her attention, but she was too drunk to notice," said Ingram. "Later it was determined that her blood alcohol content was two times over the legal limit."

"I can't even bear to think about what my brother must have gone through during and in the moments that followed the crash," Ingram said. "But I do know what my family went through in the aftermath of the crash. It was then that I knew I had to do something to prevent another family from going through that kind of pain."

Ingram responded by taking action. Her first step was to attend the 1997 MADD National Youth Summit to Prevent Underage Drinking as a youth delegate. While Ingram was at the Summit, a cheerleading squad teammate back home nearly lost her life in an impaired-driving crash. This second alcohol-related crash fueled Ingram's fire for preventing the senseless tragedy from happening to anyone else.

Armed with the knowledge and driven by the passion of a true activist, Ingram set out to make a difference. Working in conjunction with the MADD Northern Virginia chapter, she began speaking at high schools and local community colleges to educate students about the dangers of alcohol and impaired driving. She also co-founded the student-led Alcohol and Drug Abuse Prevention Team (ADAPT) on her university's campus.

"Underaged students like myself who choose not to drink didn't seem to have the same options to have fun and get together with friends as the students who do drink," Ingram

said of her impression upon arriving at [the University of Virginia] her first year. “The drinkers and partyers at the university had an outlet that was not available to students like me on campus. Students need an outlet for their energies and their leadership abilities,” she continued. “Our campus alcohol awareness program is 10 years old, but student involvement this year is the highest it has ever been because we have created new and different options for alcohol-free lifestyles.”

Community Approaches

In 1997, the Drug Free Communities Act became law. The Act was intended to increase community participation in substance abuse reduction among youth. The program is directed by the Office of Juvenile Justice and Delinquency and the White House’s ONDCP. The program supports coalitions of youth, parents, law enforcement, schools, state, local, and tribal agencies, health care professionals, faith-based organizations, and other community representatives. The coalitions rely on mentoring, parental involvement, community education, and school-based programs for drug prevention and intervention, much like Project Northland.

Based in northern Minnesota, Project Northland was the largest community trial in the United States to address the prevention of alcohol use and alcohol-related problems among adolescents (Williams and Perry 1998). Adopting a holistic approach, the project assumed that prevention efforts should be directed at adolescents and their immediate social environment (family, peers, friends) and should include larger peer groups (teachers, coaches, religious advisers) as well as the broader community of businesses and political leaders. The project was recognized for its programming by the SAMHSA, U.S. Department of Health and Human Services, and the U.S. Department of Education.

Project Northland included youth participation and leadership, parental involvement and education, community organizing and task forces, media campaigns, and school curriculum as part of its strategies for alcohol prevention. The program included two phases. Phase 1 focused on strategies to encourage adolescents not to use alcohol. Phase 2 emphasized changing community norms about alcohol use, reducing the availability of alcohol among high school students, and adopting a functionalist approach in reinforcing community norms and boundaries. Community strategies included making compliance checks of age-of-sale laws (coordinated through local police departments), holding training sessions for responsible beverage servers at retail outlets and bars, and encouraging businesses to adopt “gold card” programs where discounts are provided to students who pledge to remain free of alcohol. At the end of Phase 1, the intervention group demonstrated significant reductions in the onset and prevalence of drinking. Data are unavailable on the effectiveness of Phase 2 strategies (Williams and Perry 1998).

The Community Anti-Drug Coalitions of America (CADCA) is a nonprofit organization that provides technical assistance and training to community-based coalitions. The organization was established in 1992 by Jim Burke and Alvah Chapman and currently serves more than 5,000 anti-drug coalitions. The program provides

community groups with lobbying handbooks, alerts on drug-related legislation, funding information, and coalition training on various drug abuse topics.

One CADCA affiliate is Wilson Families in Action (WFA) of Wilson, North Carolina, incorporated in 1982. Formed by local leaders, agencies, and organizations, WFA attempts to address the growing problem of drug abuse in the community. WFA operates seven programs, including “I’m Special,” a science-based program for third and fourth graders, and the Prom “Think Card” campaign, targeting community merchants to discourage high school students from drinking alcohol at their prom.

❖ **Voices in the Community:** *Linda Elliot*

Linda Elliot founded the Parent Party Patrol because of her own teenaged son. After realizing that he was partying every weekend, she tried to find a community program that might provide her with some assistance. She discovered that there were no programs addressing what she calls the core problem—unchaperoned alcohol and drug parties. In an interview, Elliot said,

There was nothing looking at the core of the problem—where were our children getting the drugs? Where are our children getting the alcohol? I took it upon myself to educate parents about some of the behaviors that go on in unchaperoned parties and the civil and legal liabilities that are attached to parents no matter what their children do. We are all responsible for our children.

Elliot admits that she was seriously concerned for her son’s life. There were many weekends where she imagined what it would be like when someone finally called to say that he was dead. But she came to the realization that she didn’t have to live this way; Parent Party Patrol was part of her solution. Elliot became concerned not only about the drug and alcohol use, but also about the consequences of these parties: vandalism, alcohol poisoning, violence, rape, and death. “I could not believe that parents were turning a deaf ear and a blind eye to these parties.” She says she could not understand why some parents would endorse these teen behaviors. “Why would parents allow their children to party at their home? Why do parents provide the alcohol?”

Parent Party Patrol is funded by Pierce County Human Services and the King County Health Department. Elliot and her volunteer staff provide educational programs for parents, church groups, PTAs, and booster clubs. If Elliot travels outside of these counties, she requests a donation to help with costs. Parent Party Patrol offers a range of information for parents and youth: the manufacturing of fake IDs, types of alcohol consumed by boys versus girls, date rape drugs, rave parties, and the legal impact of unchaperoned parties. She estimates that the program reaches 1,500 to 2,750 parents each year. In addition to local and state honors, Parent Party Patrol was awarded the 1997 National Exemplary Substance Abuse Prevention Program of the Year by the Office of National Drug Control Policy and the Department of Health and Human Services.

After each program visit, Elliot and her staff conduct a follow-up survey with parents. “The intent of our presentation is to make parents more responsible, we have seen the results.” Elliot says that there is increased parental awareness about drug and alcohol use and more parents begin monitoring their child’s activities and behaviors. Specifically, parents report that they are unlikely to leave their children home alone, are unlikely to allow an unchaperoned party at their home, and are more likely to ask their neighbors or friends to check in with their children if they do have to leave town. In addition, the program also receives telephone calls from parents with questions about drugs found in their child’s room or with requests for assistance with their teen’s problem behavior(s).

Although Elliot thought that she would stop her work after her children grew up to be “successful good citizens,” she discovered that other parents still needed this information. She explains, “The reward is when I have a parent come up to me after two or three years to re-attend a presentation, and she will look at me at say, ‘You will never know how many lives you have saved.’ That’s the reward.”

For more information about the Parent Party Patrol, visit *Study Site Chapter 8*.

MAIN POINTS

- There seems to be no argument about the seriousness of the drug problem in the United States. In 2002, 19.5 million Americans age 12 and older reported they were current illicit drug users. It is estimated that 1 in every 13 adults is an alcoholic.
- Functionalists argue that society provides us with norms or guidelines on alcohol and drug use. A set of social norms identifies the appropriate use of drugs and alcohol.
- Conflict theorists argue that intentional decisions by powerful political and business interest groups have been made over which drugs are illegal.
- Feminists argue that theorists and practitioners in the field of alcohol and drug abuse have ignored experiences unique to women and other marginalized groups. However, there is increasing recognition of the importance of gender-sensitive treatment models.
- The interactionist perspective argues that drug abuse is learned from others; it addresses how individuals or groups are labeled abusers and how society responds to them.
- Alcohol is the most abused drug in the United States. Other abused drugs include nicotine, marijuana, methamphetamine, and cocaine. Alcohol problems can be both a cause and an excuse for intimate partner violence and child abuse. Alcohol abuse is more often suspected in crimes than abuse of any other drug.
- Employers have always been concerned about the impact of substance abuse. About 8.1 million drug abusers are employed, costing businesses billions of dollars a year.
- Binge drinking among college students has been called a major public health problem. Some research shows that students who engaged in high-risk behaviors were more likely to be binge drinkers, whereas students who were involved in community service, the arts, or studying were less likely to be binge drinkers. Thousands of college students are injured or die each year from alcohol-related driving or injuries.
- Ecstasy, Rohypnol, GHB, and Ketamine are drugs commonly used in club and rave scenes. Ecstasy has become a mainstream drug and can cause physical problems, irreparable

damage to the brain and memory, psychological difficulties long after use, and death.

- In the early 1990s, the primary sources of methamphetamines were super laboratories. More recently, there has been an increase in the number of small-scale labs operated by independent “cooks.” The waste and residue remaining from meth cooking can contaminate the surrounding area, and cleanup is very dangerous and costly.

- Three offices—the NIDA, the ONDCP, and the NIAAA—are federally funded agencies that research and educate about drug and alcohol abuse. Extensive use of illegal drugs continues despite the efforts of these three lead agencies and the War on Drugs.

- Some have explored alternatives to the War on Drugs, including legalization (removing drugs from the control of the law). Proponents argue that current laws fail to eradicate the problem; incarceration does not alleviate the drug problem, they say, and drug crimes are victimless. Proponents argue that legalization would reduce drug-related crimes and violence, make drugs cleaner, and return to citizens a basic civil liberty. Legalization is generally opposed by the medical and public health community because research shows that drugs are harmful and cause risky behaviors and criminal activity.

- As conflict and symbolic interaction theories suggest, drug laws are not enforced equally, with certain minority groups (particularly Blacks) and the lower class being singled out. Recently, however, key legislative changes suggest a shift in thinking to treatment rather than incarceration.

- Drug addiction is considered a “treatable disorder.” Treatment may be either behavioral or medical and either short or long term. Research in

the past 25 years indicates that treatment works to reduce drug intake and drug-related crimes.

- Certain employers are required by law to have drug-free workplace programs. Now, more than 81 percent of companies test employees for drugs. A drug-free workplace program likely decreases administrative work losses, hidden losses, legal losses, and health care services.

- Drug-testing programs have been subject to lawsuits in the past decade over constitutional issues. There have also been challenges to the accuracy of drug tests. Consistent with conflict theories, some have argued that drug testing promotes various political agendas and reflects the manipulation of interest groups. Yet, many U.S. companies consider drug-testing programs part of an effective policy against substance abuse.

- Employee assistance programs are the most common intervention used in the workplace to prevent and treat alcohol and other drug abuse among employees. There is some evidence of the effectiveness of these programs.

- The U.S. Supreme Court ruled that drug testing in schools is legal and an important deterrent to drug use for student athletes (1993) and for students in other extracurricular activities (2002). However, a national study of 76,000 high school students indicated that education, not testing, may be the most effective weapon against abuse.

- In general, prevention models that discourage or deglamorize alcohol and drug use are associated with better outcomes than those that merely ban or restrict substance use.

- Recent acts and initiatives to reduce substance abuse include the Drug Free Communities Act, the Community Anti-Drug Coalitions of America, and Wilson Families in Action.

INTERNET AND COMMUNITY EXERCISES

1. There are several advocacy groups committed to promoting alternative solutions to the drug problem in the United States. Two groups are Students for a Sensible Drug Policy and Stop the Drug War. Log on to *Study Site Chapter 8* for links to their Web site. Examine how both organizations define the drug problem. Are there any differences in their definitions? What solutions does each group support?

2. According to the U.S. Drug Enforcement Administration, the illegal drug market in the United States is one of the most profitable in the world. The DEA posts state fact sheets on its Web site, identifying the drug trafficking situation in each state, along with a list and description of the illicit drugs that are smuggled in the state. For information about drug trafficking in your state, go to *Study Site Chapter 8*. To what extent does drug trafficking occur in your state?

3. According to Maria Alaniz (1998), “alcohol outlet density is an important determinant of the amount of alcohol advertising in a community. Merchants use storefronts and the interiors of alcohol outlets to advertise alcohol products. Therefore, areas with a high density of outlets have a greater number of advertisements” (p. 286). Alaniz cites a study showing that a student walking home from school in a predominately Latino neighborhood in northern California may be exposed to between 10 and 60 storefront alcohol advertisements. The same study found that there are five times more alcohol advertisements in Latino neighborhoods than in predominately White neighborhoods. Count the number of alcohol outlets around your college-university, along with billboard advertising within a five-mile radius. Do these ads target college students? Do you think exposure to alcohol advertising increases alcohol consumption? Why or why not?

4. The Campaign for Tobacco-Free Kids is a national campaign effort to protect children from tobacco addiction and exposure to secondhand smoke. The campaign’s Web site includes information on state initiatives, as well as statistics on tobacco use. Log on to *Study Site Chapter 8*.

On your own. Log on to *Study Site—Community and Policy Guide* for more information about the social problems, social policies, and community responses discussed in this chapter.

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