Third Canadian Edition

DRUGS, BEHAVIOUR, AND SOCIETY

HART KSIR HEBB GILBERT

DRUGS, BEHAVIOUR, AND SOCIETY

THIRD CANADIAN EDITION

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Third Canadian Edition

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Preface to the Third Canadian Edition

Today's media-oriented college and university students are aware of many issues relating to drug use. Nearly every day we hear new concerns about the "opioid crisis," legal pharmaceuticals, and the effects of tobacco and alcohol. Most of us have had some personal experience with these issues through family, friends, or co-workers. This course is one of the most exciting students will take because it will help them relate the latest information on drugs to their effects on Canadian society and human behaviour. Not only will students be in a better position to make decisions to enhance their own health and well-being, but they will also have a deeper understanding of the individual problems and social conflicts that arise when others misuse and abuse psychoactive substances.

Much has changed in Canada over the years. Practices and patterns of psychoactive drug use, and their effects on human behaviour and Canadian society, are in a continual state of flux. The 1960s through 1970s was a period of widespread experimentation with marijuana and hallucinogens, while the 1980s brought increased concern about illegal drugs and conservatism, along with decreased use of alcohol and all illicit drugs. Not only did drug-using behaviour change, but so did attitudes and knowledge. And, of course, in each decade, including the 1990s, the particular drugs of immediate social concern changed: LSD gave way to heroin, then to cocaine and crack, and today to prescription medications.

Recent Trends

The most alarming trend in recent years has been the increased misuse of prescription opioid pain relievers such as fentanyl. This pharmaceutical has now joined cocaine, methamphetamine, and ecstasy as leading causes of concern about drug misuse and abuse. Methamphetamine, ecstasy, GHB, and the misuse of prescription opioids and performance enhancers are the big news items.

Meanwhile, our old standbys, alcohol and tobacco, remain with us and continue to create serious health and social problems. Regulations undergo frequent changes, new scientific information becomes available, the legal status of certain drugs has changed (e.g., cannabis), and new approaches to prevention and treatment are being tested. But in spite of all these changes, the often grim realities of substance use and abuse always seem to be with us.

This text approaches drugs and drug use from a variety of perspectives—behavioural, pharmacological, historical, social, legal, and clinical—and will help students connect the content to their own interests.

What's New in the Third Canadian Edition

In developing this edition, we considered the outlook and experiences of Canadian students.

Throughout each chapter, we have included the latest Canadian statistics, and the "Drugs in the Media" feature has allowed us to include breaking news right up to press time. Additionally, we have introduced many timely topics and have highlighted cutting-edge research by and practices of Canadians. Collectively, these will pique students' interest and stimulate class discussion.

The following are just some of the new and updated topics in the Third Canadian Edition.

- **Chapter 1**: Broadened discussion of the fentanyl outbreak; updated tables, images, and source materials.
- **Chapter 2**: Heavily contextualized to the Canadian perspective, DAWN data has been removed, and numerous tables updated with new material incorporated; most up-to-date criteria for the diagnosis of substance-related and addictive disorders (cannabis), as defined by the DSM-5.
- **Chapter 3**: Added information on medicinal marijuana and the recent legislative move to legalize marijuana in Canada in 2018.
- **Chapters 4** and **5**: Improved clarity for topics that are most challenging to students: biology, CNS, and neuroscience. Language revised to ensure content is easily understood by both novice students and those with more specialized backgrounds.
- **Chapter 5**: New Drugs in the Media focus box on "Opioid Crisis in Canada."
- **Chapter 6**: New Mind/Body Connection focus box on "Cocaine"; new Drugs in Depth box on methamphetamine addiction.
- **Chapter 7**: Chapter title has changed to "Depressants and Inhalants"; revised "Causes for Concern" section; content more inclusive with greater discussion of Canada's Indigenous communities.
- **Chapter 8**: New learning objective added for this chapter to reflect added coverage on the stigmas associated with mental illness and Canadian strategies to help address these issues.
- **Chapter 9**: Updated CTADS survey data (to replace CADUMS data) on Canadian drug use; updated statistical data on CAUT-sponsored surveys of postsecondary institutions (conducted in 2013 and 2016).

- **Chapter 10**: Increased coverage of vaping and expanded discussion of neurophysiological effects of nicotine; updated Canadian statistics on cigarette use in Canada and in youth; new Mind/Body Connection focus box on "Smoking and Mental Illness."
- **Chapter 11**: Updated DSM-5 boxes "Caffeine Intoxication" and "Caffeine Withdrawal Disorder"; new Mind/Body Connection box on "Caffeine: Canada's Favourite Drug"; new Drugs in the Media box "Are Canadians Trading Their 'Double-Doubles' for Tea?"
- **Chapter 12**: Revised Drugs in Media box; updated Mind/Body Connection focus box. Heavily contextualized to the Canadian perspective and links to Web resources updated.
- **Chapter 13**: Increased coverage of opioid crisis in Canada with a focus on fentanyl; new research and issues around addiction, health, and prevention of harms.
- **Chapter 14**: Updated Canadian statistics that define current trends in hallucinogen use with particular emphasis on youth. A closer look at ecstasy.
- **Chapter 15**: Expanded discussion on legalization of marijuana both in Canada and the United States, including the impact so far, benefits and risks currently in the United States (Colorado specifically), and concerns here in Canada.
- **Chapter 16**: Updated information on the prevalence of substance misuse by Canadian youth and young adults for the purpose of enhancing performance.
- **Chapter 17**: Revised prevalence data that defines Canada's current substance misuse challenges. A consideration of recent Canadian efforts to better understand contributors to substance misuse. Updated discussions of the weaknesses of past prevention programs and information that supports readers in identifying prevention approaches with proven efficacy.
- **Chapter 18**: Updates on the findings of recent studies that evaluated the effectiveness of commonly used pharmacological and behavioural treatment approaches. An update on the measured successes of Insite, Canada's first supervised injection facility.

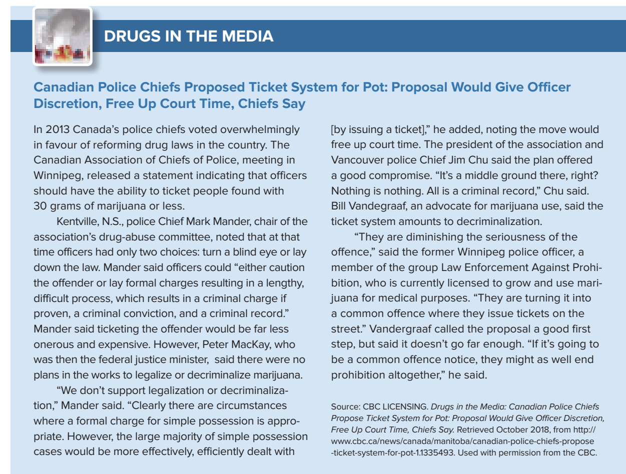
A **subject index** has also been added to the endmatter of this edition to provide readers with a concise listing of references to supplement their reading experience.

Focus Boxes

Focus boxes are used in *Drugs, Behaviour, and Society* to explore a wide range of current topics in greater detail than is possible in the text itself. The boxes are organized around key themes.

Drugs in the Media

Our world revolves around media of all types: TV, films, radio, print media, and the Web. To meet students on familiar ground, the Drugs in the Media boxes take an informative and critical look at these media sources of drug information. Students can build their critical thinking skills while reading about such topics as alcohol advertising, media coverage of prescription drugs, and the presentation of cigarette smoking in films.



DRUGS IN THE MEDIA

Canadian Police Chiefs Proposed Ticket System for Pot: Proposal Would Give Officer Discretion, Free Up Court Time, Chiefs Say

In 2013 Canada's police chiefs voted overwhelmingly in favour of reforming drug laws in the country. The Canadian Association of Chiefs of Police, meeting in Winnipeg, released a statement indicating that officers should have the ability to ticket people found with 30 grams of marijuana or less.

Kentville, N.S., police Chief Mark Mander, chair of the association's drug-abuse committee, noted that at that time officers had only two choices: turn a blind eye or lay down the law. Mander said officers could "either caution the offender or lay formal charges resulting in a lengthy, difficult process, which results in a criminal charge if proven, a criminal conviction, and a criminal record." Mander said ticketing the offender would be far less onerous and expensive. However, Peter MacKay, who was then the federal justice minister, said there were no plans in the works to legalize or decriminalize marijuana.

"We don't support legalization or decriminalization," Mander said. "Clearly there are circumstances where a formal charge for simple possession is appropriate. However, the large majority of simple possession cases would be more effectively, efficiently dealt with [by issuing a ticket]," he added, noting the move would free up court time. The president of the association and Vancouver police Chief Jim Chu said the plan offered a good compromise. "It's a middle ground there, right? Nothing is nothing. All is a criminal record," Chu said. Bill Vandegraaf, an advocate for marijuana use, said the ticket system amounts to decriminalization.

"They are diminishing the seriousness of the offence," said the former Winnipeg police officer, a member of the group Law Enforcement Against Prohibition, who is currently licensed to grow and use marijuana for medical purposes. "They are turning it into a common offence where they issue tickets on the street." Vandergraaf called the proposal a good first step, but said it doesn't go far enough. "If it's going to be a common offence notice, they might as well end prohibition altogether," he said.

Source: CBC LICENSING. *Drugs in the Media: Canadian Police Chiefs Propose Ticket System for Pot: Proposal Would Give Officer Discretion, Free Up Court Time, Chiefs Say.* Retrieved October 2018, from http://www.cbc.ca/news/canada/manitoba/canadian-police-chiefs-propose-ticket-system-for-pot-1.1335493. Used with permission from the CBC.

Taking Sides

These boxes discuss a particular drug-related issue or problem and ask students to take a side in the debate. This thought-provoking material will help students apply what they have learned in the chapter to real-world situations. Taking Sides topics include potential medical uses of marijuana, current laws relating to drug use, and the issue of government funding for research on hallucinogens.

TAKING SIDES

Can We Predict or Control Trends in Drug Use?

Looking at the overall trends in drug use, it is clear that significant changes have occurred in the number of people using marijuana, cocaine, alcohol, and tobacco. However, while it's easy to describe the changes once they have happened, it's much tougher to predict what will come next. Maybe even harder than predicting trends in drug use is knowing what social policies are effective in controlling these trends. The two main kinds of activities that we usually look to as methods to prevent or reduce drug use are legal controls and education (including advertising campaigns). How effective do you think laws have been in helping prevent or reduce drug use? Be sure to consider in your analysis laws regulating sales of alcohol and tobacco to minors. What about the public advertising campaigns you are familiar with? How about school-based prevention programs? As you read this book, these questions will come up again, along with more information about specific laws, drugs, and prevention programs. For now, choose which side you would rather take in a debate on the following proposition: Broad changes in drug use reflect shifts in society and are not greatly influenced by drug-control laws, antidrug advertising, or drug-prevention programs in schools.

Mind/Body Connection

These boxes highlight the interface between the psychological and the physiological aspects of substance use, abuse, and dependence. These boxes help students consider influences on their own attitudes toward drug use. Topics include religion and drug use, the social and emotional costs of smoking, and the nature of dependence.

MIND/BODY CONNECTION

Expanding Drug Treatment Courts in Canada

A drug treatment court (DTC) provides judicially supervised treatment in lieu of prison time for individuals who have a substance use problem related to their criminal activities (e.g., drug-related offences, such as drug possession, use, or noncommercial trafficking or property offences committed to support their drug use, such as theft or shoplifting). The eligible accused must decide between the DTC program and customary criminal justice processing that ranges from fines to incarceration. Typically, formal admission into a DTC program requires the individual to plead guilty to the charges. If an individual fails to comply or participate in all aspects of the program, consequences range from an official reprimand or revocation of bail to expulsion from the program.

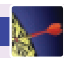
DTC participants are required to attend both individual and group counselling sessions and receive appropriate medical attention (such as methadone treatment) and are subject to random drug tests. Participants must also appear regularly in court, where a judge reviews their progress and can then either impose sanctions or provide rewards (ranging from verbal commendations to a reduction in court appearances). DTC staff work with community partners to address participants' other needs, such as safe housing, stable employment, and job training. Once a participant gains social stability and can exhibit control over their substance use problem, criminal charges are either stayed (suspended or postponed judgment) or the offender receives a noncustodial sentence (restrictions other than jail, including house arrest).

The first Canadian DTC was established in Toronto in 1998 as collaboration among the Centre for Addiction and Mental Health, the Provincial Court of Ontario, Justice Canada, the Toronto Police Service, and other community-based organizations. The DTC of Vancouver was opened in December 2001 to address the high rates of heroin use and cocaine and crack cocaine use in Vancouver. In 2003, the federal government underscored its support for the use of DTCs in Canada by dedicating monies to support the continued operation of the two existing Canadian DTCs and to facilitate the development, implementation, and operation of four additional sites in Ottawa, Winnipeg, Regina, and Edmonton. Today these DTCs are funded through the Drug Treatment Court Funding Program (DTCFP), which is administered by Justice Canada. The cost of funding Canada's six DTCs is approximately $3.5 million per year. A responsibility of the DTCFP is to collect information and data on the effectiveness of DTCs for the purpose of promoting best practices and ongoing program development. A formal evaluation of the programs' outcomes was conducted in 2014. This evaluation found positive trends that suggest DTCs are supporting participants in their reduction of drug use, social stability (family relationships, employment, and housing), and avoidance of criminal involvement. Unfortunately, the presentation of this study's methodology and demonstrated approach to data analysis lacked methodological rigour.

Source: Department of Justice. February 7, 2017. Drug Treatment Court Funding Program Evaluation. Accessed February 1, 2018, from http://www.justice.gc.ca/eng/rp-pr/cp-pm/eval/rep-rap/2015/dtcfp-pfttt/p2.html.

Targeting Prevention

These boxes offer perspective and provoke thought regarding which drug-related behaviours we, as a society, want to reduce or prevent. Topics include syringe exchange programs, criminal penalties for use of date-rape drugs, and nondrug techniques for overcoming insomnia. These boxes help students better evaluate prevention strategies and messages.



TARGETING PREVENTION

Prescribing Practices

Under Canada's Controlled Drugs and Substances Act, scheduled drugs for medical treatment may be legally obtained only with a prescription from a licensed medical practitioner (including dental and veterinary practitioners). However, many of these scheduled prescription medications (e.g., opioids, benzodiazepines, cannabis, amphetamines) have the potential for patients to abuse them or to become dependent on them. Prescribing rules vary, but one of the most common limitations is that the prescriptions may not be automatically refilled. In other words, the physician must write a new prescription if the patient wants to get more of the drug. Despite these rules, we are hearing more and more about people who develop dependence on prescription drugs. Do you think the current limitations are effective? Could changes be made that would effectively reduce the chances of patients becoming dependent?

Drugs in Depth

These boxes examine specific, often controversial, drug-related issues, such as the growing number of people in prison for drug-related offences. Drugs in Depth boxes are a perfect starting point for class or group discussion.

DRUGS IN DEPTH

Opioid Contracts: Mandatory Drug Testing for Chronic Pain Patients. Who Benefits?

In an article published in the *Chronicle Herald,* patients that are being seen at the Centre for Pain Management in Halifax are being asked to subject to a urinary toxicology screen to determine what, if any, drugs (illicit or legal) the patient is consuming. "Shelley Brown, a former patient at the Centre for Pain Management, said the requirement violates her rights. The Mahone Bay woman, who has a form of leukemia that causes severe pain, was upset at being told last week that she wouldn't be treated unless she provided a sample" (McPhee, 2011). This mandatory drug test is being proposed necessary to determine whether or not patients receiving an opioid for pain, in conjunction with medications/drugs presently consumed, are at increased risk of harm both from an overdose and from an addiction perspective. Does the patient really benefit, or is it a means of discrimination? The result of this story was a buzz of information on social media, and there is reference to its utility on PubMed. A question emerges in light of this news story: "Is it ethical to subject patients to mandatory drug tests and what will be done with this information? In a quantitative design, what number of clients that receive opioids also test positive for other drugs, legal or illicit? What evidence exists that these 'opioid contracts' improve care and possess efficacy to reduce opioid addiction?" (Collen, 2009). These are all questions that may be answered by prospective clinical studies following patients being treated for chronic pain.

In addition to gathering data, clinical measures need to be put in place by the interdisciplinary team for methods of treating pain other than with the administration of opioids. On the team would be a social worker/counsellor to talk with the client about population studies, a physician to be involved in establishing proper (non-judgmental) guidelines for the prescription of opioids, a nurse trained to recognize signs of addiction as well as pain, a psychologist to assess for depression or anxiety disorders that might exacerbate pain syndromes, a physiotherapist to initiate non-pharmacological strategies for pain (e.g., massage, heat), and a toxicologist trained in drug testing to rule out false positive and negative results. With well-controlled studies, the factors leading to addiction in these patients may be identified, the care of individuals with a higher risk for opioid misuse improved, and the costs and dangers of drug use could be greatly reduced.

continued

DSM-5

The *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), the handbook used by health care professionals as the authoritative guide to the diagnosis of mental disorders, has been updated. DSM-5 boxes and content throughout the text reflect current recommendations and concepts presented in the DSM-5.

DSM-5

Post-Traumatic Stress Disorder (PTSD)

- Note: The following criteria apply to adults, adolescents, and children older than 6 years.

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g. first responders collecting human remains; police officers repeatedly exposed to details of child abuse).
   - Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:
1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).
   - Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).
   - Note: in children, there may be frightening dreams without recognizable content.
3. Dissociative reactions to (e.g. flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)
   - Note: in children, trauma-specific reenactment may occur in play.
4. Intense of prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:
1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).
2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").
3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest of participation in significant activities.
6. Feelings of detachment or estrangement from others.
7. Persistent inability to experience positive emotions (e.g. inability to experience happiness, satisfaction, or loving feelings).

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
1. Irritable behaviour and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.

continued

Pedagogical Aids

Although all the features of *Drugs, Behaviour, and Society* are designed to facilitate and improve learning, several specific learning aids have been incorporated into the text:

Chapter Objectives

Chapters begin with a list of numbered objectives that identify the major concepts and help guide students in their reading and review of the text.

Definitions of Key Terms

Key terms are set in boldface type in the running text and are defined in corresponding boxes. Other important terms in the text are set in italics for emphasis. Both approaches facilitate vocabulary comprehension.

Chapter Summaries

Each chapter concludes with a bulleted summary of key concepts. Students can use the chapter summaries to guide their reading and review of the chapters.

Review Questions

A set of questions appears at the end of each chapter to aid students in their review and analysis of chapter content.

Appendices

The appendices include handy references on brand and generic names of drugs and on drug resources and organizations. These are available online in Connect.

Drugs of Abuse: Uses and Effects

A helpful chart of drug categories, uses, and effects appears on the front inside cover of the text.

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Connect Insight®

Connect Insight is Connect's new one-of-a-kind visual analytics dashboard—now available for instructors—that provides at-a-glance information regarding student performance, which is immediately actionable. By presenting assignment, assessment, and topical performance results together with a time metric that is easily visible for aggregate or individual results, Connect Insight gives instructors the ability to take a just-in-time approach to teaching and learning, which was never before available. Connect Insight presents data that helps instructors improve class performance in a way that is efficient and effective.

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- Assign SmartBook learning modules.
- Instructors can edit existing questions and create their own questions.
- Draw from a variety of text-specific questions, resources, and test bank material to assign online.
- Streamline lesson planning, student progress reporting, and assignment grading to make classroom management more efficient than ever.

Smart Grading

When it comes to studying, time is precious. Connect helps students learn more efficiently by providing feedback and practice material when they need it, where they need it.

- Automatically score assignments, giving students immediate feedback on their work and comparisons with correct answers.
- Access and review each response; manually change grades or leave comments for students to review.
- Track individual student performance—by question, assignment, or in relation to the class overall—with detailed grade reports.
- Reinforce classroom concepts with practice tests and instant quizzes.
- Integrate grade reports easily with Learning Management Systems including Blackboard, D2L, and Moodle.

Mobile Access

Connect makes it easy for students to read and learn using their smartphones and tablets. With the mobile app, students can study on the go—including reading and listening using the audio functionality—without constant need for Internet access.

Instructor Library

The Connect Instructor Library is a repository for additional resources to improve student engagement in and out of the class. It provides all the critical resources instructors need to build their course.

- Access instructor resources.
- View assignments and resources created for past sections.
- Post your own resources for students to use.

Instructor Resources

The following instructor resources are available for download from Connect. To obtain a password to download these teaching tools, please contact your local sales representative.

Instructor's Manual

Prepared by Dr. Robert Gilbert, Dalhousie University. Organized by chapter, the Instructor's Manual includes chapter outlines, key points, suggested class discussion questions and activities, and video suggestions.

Computerized Test Bank

Prepared by Anastasia Bake, University of Windsor and St. Clair College of Applied Arts and Sciences. The Test Bank has been revised to improve the quality of questions. Each question is ranked by level of difficulty, which allows greater flexibility in creating a test and also provides a rationale for the solution.

Microsoft® PowerPoint® Slides

Prepared by Dr. Andrea Lyn Olding Hebb, Saint Mary's University. With figures and exhibits from the text, the PowerPoint slides include key lecture points and images from the text and other sources.

Image Bank

Contains more than 200 full-colour figures and images from the text.

Additional Online Resources

- Appendix A: Drug Names
- Appendix B: Resources for Information and Assistance

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We recognize the diverse backgrounds and levels of expertise of our readers and encourage you to send any comments or suggestions about this Third Canadian Edition to us at rgilbert@dal.ca (Robert Gilbert). Your input is essential to the development of future editions.

Finally, we are extremely grateful to our colleagues from across Canada who reviewed the Second Canadian Edition, which helped lay the blueprint for this title. Their input and expertise have enhanced our knowledge and enriched the content of this book in a valuable way. We acknowledge these individuals in the list that follows. Thank you for your insightful suggestions.

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Sincerely,
Andrea L.O. Hebb & Robert W. Gilbert

Section 1

Chapter 1
Drug Use: An Overview

Which drugs are being used and why?

Chapter 2
Drug Use as a Social Problem

Why does our society want to regulate drug use?

Chapter 3
Drug Policy

What are the regulations, and what is their effect?

Drug Use in Modern Society

The interaction between drugs and behaviour can be approached from two general perspectives. Certain drugs, the ones we call *psychoactive,* have profound effects on behaviour. Part of what a book on this topic should do is describe the effects of these drugs on behaviour, and later chapters do that in some detail. Another perspective, however, views drug taking as behaviour. The psychologist sees drug-taking behaviours as interesting examples of human behaviour that are influenced by many psychological, social, and cultural variables. In the first section of this text, we focus on drug taking as behaviour that can be studied in the same way that other behaviours, such as aggression, learning, and human sexuality, can be studied. You will also be given information on the pharmacological and social aspects of recreational drugs so that you will be able to make informed choices on drug use.

Chapter 1

Drug Use: An Overview

Monkeybusinessimages/Getty Images

Drug use is on the rise among older adults in Canada. The use of multiple medications (*polypharmacy*) increases the risks of adverse drug events and interactions.

OBJECTIVES

When you have finished this chapter, you should be able to

LO1 Develop an analytical framework for understanding any specific drug-use issue.

LO2 Apply four general principles of psychoactive drug use to any specific drug-use issue.

LO3 Explain the differences among misuse, abuse, and dependence.

LO4 Describe the concepts of dependence, tolerance, and withdrawal.

LO5 Explain correlates and antecedents of adolescent drug use.

LO6 Explain risk factors and protective factors for drug use.

LO7 Discuss motives that people may have for illicit or dangerous drug-using behaviour.

LO1 LO2 LO3 LO4

The Drug Problem

"Drug use on the rise" is a headline that has been seen quite regularly over the years. It gets our attention. At any given time, the unwanted use of some kind of drug can be found to be increasing, at least in some group of people. How big a problem does the current headline represent?

Talking about Drug Use

Before we can evaluate the extent of a drug problem or propose possible solutions, we need to be more specific about just what the problem is. It's obvious that not all types of drug use demand our concern. If your Aunt Joan has a headache and takes two Tylenol tablets, that's drug use, but most of us don't see it as a problem. However, Uncle John's continued need for pain medication even though his injury has healed, and your best friend Laura's dependence on alcohol for social interactions at parties, may be viewed as problem drug use. Whether prescription or illicit, some drugs being used by some people in some situations are a problem our society must deal with. Let's look at some of the factors that determine whether a particular kind of drug use is a problem that we should attend to.

Journalism students are told that an informative news story must answer the questions who, what, when, where, why, and how. Let's see how answering the same questions, and one more question—how much—can help us analyze problem drug use.

- Who is taking the drug? The majority of Canadians perceive drug and alcohol abuse to be very or somewhat serious problems in Canada, their province or territory, and their community.[1] However, we are more concerned about a 15-year-old girl drinking a beer than we are about a 21-year-old woman doing the same thing. We worry more about a 15-year-old boy smoking marijuana than we do about a 40-year-old man smoking it. Images on YouTube of children as young as two years of age in other parts of the world smoking, whether real or not, are especially disturbing. And although we don't like the idea of anyone taking heroin, we undoubtedly get more upset when we hear about the girl next door becoming a user.
- What drug are they taking? This question should be obvious, but often it is overlooked. A simple claim that a high percentage of students are "drug users" doesn't tell us if there has been an epidemic of methamphetamine use or if the drug is alcohol (which is more likely). If someone begins to talk about a serious "drug problem" at the local high school, the first question should be, What drug or drugs?
- When and where is the drug being used? The situation in which the drug use occurs often makes all the difference. The clearest example is the drinking of alcohol; if it is confined to appropriate times and places, most people accept drinking as normal behaviour. When an individual begins to drink on the job, at school, or in the morning, that behaviour may be evidence of a drinking problem. Even subcultures that accept the use of illegal drugs might distinguish between acceptable and unacceptable situations; some university-age groups might accept marijuana smoking at a party but not just before going to a psychology class!
- Why a person takes a drug or does anything else is a tough question to answer. Nevertheless, it is important in some cases. If a person takes Vicodin because her doctor prescribed it for the knee injury she got while skiing, most of us would not be concerned. If, however, she takes that drug on her own, just because she likes the way it makes her feel, then we should begin to worry about possible abuse of the drug. The motives for drug use, as with motives for other behaviours, can be complex. Even the person taking the drug might not be aware of all the motives involved. One way a psychologist can try to answer *why* questions is to look for consistency in the situations in which the behaviour occurs (when and where). If a person drinks only with other people who are drinking, we may suspect social motives; if a person often drinks alone, we may suspect that the person is trying to deal with personal problems by drinking.
- How the drug is taken can often be critical. Indigenous South Americans who chew coca leaves absorb cocaine slowly over a long period. The same total amount of cocaine snorted into the nose produces a more rapid, more intense effect of shorter duration and probably leads to much stronger dependence. Smoking cocaine in the form of "crack" produces an even more rapid, intense, and brief effect, and dependence occurs very quickly.
- How much of the drug is being used? This isn't one of the standard journalism questions, but it is important when describing drug use. Often the difference between what is considered normal use and what is considered abuse of, for example, alcohol or a prescription drug comes down to how much a person takes.