



## **SWK 3805: Module 1- Introduction & Overview**



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# Module 1: Preface

Welcome to the online coursebook for Module 1 of our Theories and Biological Basis of Addiction course. The material is designed to be read interactively or after downloading; while the embedded interactive exercises require internet connectivity, each can also be downloaded for offline work. These exercises are presented to help you test and apply what you are reading, challenge yourself, prepare for quizzes, and have a little fun along the way. The list of key terms at the end explains text ***highlighted in bold italics*** throughout the book—in the interactive mode you can click on a highlighted word to jump to its explanation in the key terms section. Use the back arrow to return to where you were reading.



# Module 1: Introduction

The readings for Module 1 introduce many of the concepts and a bit of background for the course on Theories and Biological Basis of Addiction. This book includes a section developed by the author (chapters 1-3) and a published article.

## Module 1 Reading Objectives

After engaging with all of these reading materials and learning resources, you should be able to:

- List the major categories of psychotropic substances which people tend to misuse or become addicted;
- Explain current statistics related to who engages in substance use and misuse, as well as who experiences substance use disorders;
- Recognize several key historical trends and policies addressing substance use and addiction;
- Define key terms related to substance use; and,
- Identify and resolve where stigmatizing language about substance use and addiction occurs.



# Ch. 1: Psychoactive Substances

In the first three chapters<sup>1</sup>, you will read about:

- the major types of psychoactive substances;
- key epidemiology trends related to substance use and misuse;
- major historical and current trends in policy and practice related to substance use and substance use disorders; and,
- key terms used in the field of substance use, misuse, and addiction.

<sup>1</sup> Note: Portions of these chapters derived from Begun, A. (in press). Substance use disorders. Chapter to appear in S. Kapp, (Ed.), *Introduction to social work*. Thousand Oaks, CA: Sage.

## Psychoactive Substances

Our course focuses on **psychoactive substances**. Psychoactive substances are chemicals affecting how the brain functions, and thus have the power to affect a person's mind, mood, and behavior when consumed. The word **psychotropic** means the same thing. Many of these substances have important medicinal or other positive purposes when used appropriately. Many also are the subject of concern because of the consequences arising from their misuse and the potential for their use evolving into a substance use disorder.

## Types of Substances

One way of organizing the very long list of psychoactive substances is in terms of their actions on the human body. It would be impossible to list every one of these drugs because the list is constantly evolving: not only are new nicknames for drugs being invented all the time, new formulations (drugs) are being developed on a regular basis. In addition, some substances do not fit neatly into a single category. For example, it is difficult to know how to classify caffeinated energy drink plus alcohol beverages (e.g., Four Loko®, Joose®, Sparks+®, Jaegerbombs, or vodka with Red Bull®) since their components fall into two very different categories: caffeine and some other ingredients are stimulants; alcohol is a depressant. (Note that premixed beverages of this type no longer are sold in most of the United States but are still produced for consumption in other nations.)

In many sources, there is a distinction made between legal or illegal “street” drugs. However, this distinction has two major flaws. First, we have seen a tremendous upsurge in the illegal use of legal substances in recent years—by now, you have heard about the problem of prescription drug abuse in the news. Second, laws can change, as we have witnessed recently with states legalizing various uses of marijuana, and laws concerning the legal drinking age that have fluctuated in the United States between 21, 18, 19, and back to 21 just since the 1970s.

The way that clinicians and researchers categorize psychoactive substances is in terms of their effects on the human body or behavior. Tables 1-7 present you with just such a list. Considering some of the substances with which you or people you know may have experience, does it surprise you to see how they are classified? Some people are surprised to see alcohol classified as a depressant, or caffeine and tobacco in the same (stimulant) category as cocaine! The different substances in each category have meaningful psychoactive differences from each other. However, it is important to recognize that they also have some shared common features in terms of how they affect the mind, body, and behavior. We will be looking into each of these different types of substances in the second half of our course. For now, we are aiming for a general overview of the picture concerning “what’s what” in the array of psychoactive substances.

Table 1. *Stimulants*

Examples of Stimulant Drugs	Usual Administration Route & Common Effects
amphetamines (dexadrine, bennies, black beauties, hearts, speed, uppers); attention deficit disorder and narcolepsy medications (e.g., Adderall, Concerta, Ritalin); “bath salts;”  caffeine	Administration: Snorted, smoked, injected, swallowed; caffeine also chewed in gum, absorbed through skin in a patch.  Effects: Increased heart rate and blood pressure, elevated body temperature, increased body metabolism, reduced appetite, increased energy, feelings of exhilaration and mental alertness, tremors, irritability, anxiety, panic, paranoia, violence and aggression, psychosis. Increased risk of insomnia, weight loss, cardiovascular complications, stroke, seizures, addiction, fatal overdose.
cocaine and “crack” cocaine (blow, C, candy, coke, flake, rock, snow, toot)	Administration: Snorted, smoked, injected.  Effects: Nasal damage from snorting, exposure to infectious diseases from injection, poor pregnancy outcomes, and see amphetamines effects above.
methamphetamine (meth, ice, crank, crystal, fire, glass, speed)	Administration: Snorted, smoked, injected, swallowed.  Effects: Severe dental problems, poor pregnancy outcomes, explosion/fire risks during production, chemical and environmental contamination from production activities, and see amphetamines effects above.
MDMA (Ecstasy, “club drug” combination of stimulants and hallucinogens of various types)	Administration: Swallowed.  Effects: Feelings of euphoria, enhanced mental and emotional clarity, sensations of lightness and floating and other hallucinations, suppression of appetite, thirst, and need for sleep, anxiety, nausea, blurred vision, faintness, high blood pressure, tremors, seizures, elevated body temperature. Increased risk of exhaustion, severe dehydration, sleep disorders, cognitive impairment, confusion, depression, aggression, impulsive behavior, fatal overdose, possible addiction.
tobacco products, nicotine (cigarettes, bidis, cigars, cigarillos, pipe tobacco, e-cigarettes, hookah tobacco, snuff, chew, nicotine patch or nicotine gum)	Administration: Smoked, snorted, chewed; absorbed through skin in a patch.  Effects: increased blood pressure and heart rate. Increased risk of chronic lung disease, heart disease, stroke, cancers (mouth, throat, stomach, pancreas, cervix, kidney, bladder, acute myeloid leukemia), poor pregnancy outcomes, overdose (young children), addiction.

Table 2. *Depressants and Dissociatives*

Examples of Depressant & Dissociative Drugs	Usual Administration Route & Common Effects
alcohol (ethanol, ethyl alcohol, etoh)	<p>Administration: swallowed; some are smoked, chewed, or injected</p> <p>Effects, low dose: euphoria, mild stimulation, relaxation, lowered inhibition;</p> <p>Effects, high dose: drowsiness, slurred speech, nausea, emotional volatility, poor coordination, impaired perception, impaired memory, sexual dysfunction, loss of consciousness, impaired breathing. Increased risk of injury, depression, neurologic and cognitive deficits, memory loss, high blood pressure, liver and heart disease, poor pregnancy outcomes, addiction, fatal overdose.</p>
anti-anxiety medications	
benzodiazepines	
dextromethorphan (DXM) in large amounts (some cough medicine formulations)	
pre-anesthesia medications (rohypnol)	
PCP (phencyclidine; angel dust)	
salvia	
sleep medications	
tranquilizers (“tranqs”)	

Table 3. *Cannabinoids*

Examples of Cannabinoids:	Usual Administration Route & Common Effects
<p>marijuana (blunt, dope, ganja, grass, herb, joint, “J,”bud, Mary Jane, pot, reefer, smoke, weed);</p> <p>hashish (“hash”);</p> <p>synthetic marijuana compounds</p>	<p>Administration: Smoked, swallowed.</p> <p>Effects: Euphoria, relaxation, slowed reactions, distorted sensory perception, impaired balance and coordination, increased heart rate, increased appetite, impaired learning and memory, anxiety, psychosis. Increased risk of respiratory effects and infections, declining mental health, addiction, unknown effect on pregnancy outcomes. Potential harm from additives.</p>

Table 4. *Opiates, Opioids, & Other Pain Relievers (Analgesics)*

Examples of opiates, opioids, & other pain relievers	Usual Administration Route & Common Effects
heroin, morphine (and morphine derivatives), opium (laudanum, paregoric, gum, big O, block, black stuff), oxycodone, oxycontin, hydrocodone, percocet, fentanyl, demerol, darvon/darvocet	Administration: Injected, smoked, swallowed, snorted.  Effects: Euphoria, drowsiness and sedation, nausea, impaired coordination, confusion, constipation, slowed breathing. Increased risk of exposure to infectious diseases (hepatitis, HIV), poor pregnancy outcomes, fatal overdose, addiction. Potential harm from inconsistent dosing and additives.
methadone	Administration: Swallowed, injected  Effects: Like opioids, used to treat opioid addiction; overdose risk, slowed breathing rate

Table 5. *Hallucinogens & Psychotomimetics*

Examples of hallucinogenic & psychotomimetic drug	Usual Administration Route & Common Effects
LSD (lysergic acid diethylamide), mescaline (peyote), psilocybin ("magic" mushrooms)	Administration: swallowed, absorbed through oral tissues  Effects: altered perceptions and feelings; hallucination, increased heart rate, blood pressure, body temperature, numbness, dizziness, sleeplessness, possibly paranoia/panic; may develop "flashback" experiences later

Table 6. *Steroids*

Examples of Steroids	Usual Administration Route & Common Effects
anabolic & androgenic steroids ( <i>not to be confused with corticosteroids</i> )	Administration: injected, swallowed, absorbed through the skin  Effects: hypertension, changes in blood chemistry, liver damage, aggression, acne, infertility and other reproductive system changes

Table 7. *Inhalants*

Examples of Inhalants	Usual Administration Route & Common Effects
household & industrial aerosols (paint thinner, gasoline, glue, butane, refrigerant gases) nitrous oxide/laughing gas ("whippets," "poppers")	Administration: inhaled  Effects: stimulant followed by depression, impaired memory, nervous system disruption, muscle weakness, damage to the cardiovascular and/or respiratory system, loss of consciousness; risk of sudden death

## Ch. 2: Who (Mis)Uses These Substances?

If you are wondering just how common substance use and substance use disorders are, you will soon find this to be a more complex question than it might at first appear to be. The answer varies by:

- type of substance
- age group
- gender
- geographic location
- ethnicity, and
- co-occurring problems.

Based on the popular media, you might have the impression that just about everyone is misusing drugs (except maybe you and a few people in your personal network); this just isn't so. The science of epidemiology can help us pinpoint what actually IS going on in terms of trends and patterns related to substance use and misuse, as well as the experience of substance use disorders and other negative consequences.



**Before you read on, take a moment to jot down your best guess as to**

- *What do you think are the 2 or 3 most commonly used sub*



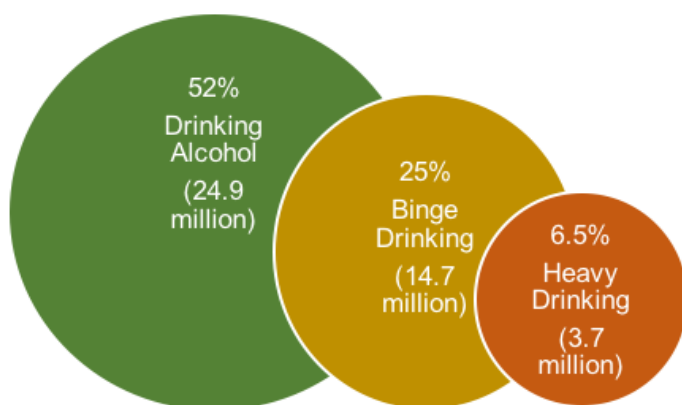
- What percentage of people aged 12 and older do you think use each of those most common substances that you identified?
- What do you predict is the distribution of men versus women using these substances?
- What age group do you predict is the highest user of the substances that you identified?
- What did you predict about the patterns of substance use among people who are white, black, Hispanic/Latino, and Native American?
- What percentage of the population do you think has a diagnosable substance use disorder?

## Epidemiological Studies

Several large-scale epidemiological studies are routinely conducted in the United States that help us develop a picture concerning the prevalence and incidence rates for substance use and substance use disorders. Still other studies provide insight about global patterns. Here are some findings from approximately 57,146 persons aged 12 and over, living in the United States, who responded to the 2015 [National Survey on Drug Use and Health \(NSDUH\)](#) reported by the [Substance Abuse and Mental Health Services Administration \(SAMHSA\)](#), 2016).

**Type of Substance:** What is most commonly used substance? Alcohol. Just over half of survey participants indicated that they had used alcohol during the past month (52 percent). This translates to over 138 million Americans considered as “current drinkers.” Keep in mind that, although alcohol was the substance most commonly used, only a portion of people who drink alcohol do so in potentially problematic ways (see Figure 1).

Figure 1. Percent reporting past month drinking alcohol, binge drinking, and heavy drinking (derived from SAMHSA, 2016 report for persons aged 12+)



The NSDUH study investigators defined past month **binge drinking** as five or more drinks containing alcohol on the same occasion on at least one day out of the past 30 days. According to NIAAA, drinking in a manner that raises a person’s **blood alcohol concentration (BAC)** to 0.08g/dL or higher is binge drinking. By comparison,

past month **heavy drinking** was defined in the survey as five or more drinks on the same occasion, on each of five or more days in the past 30 days. The amount and rate of alcohol consumption will be factors in this outcome, along with aspects of individual differences in constitution. In general, for women this means about four drinks in about two hours or five drinks in two hours for men. This pattern sometimes is referred to as risky single occasion drinking (RSOD).

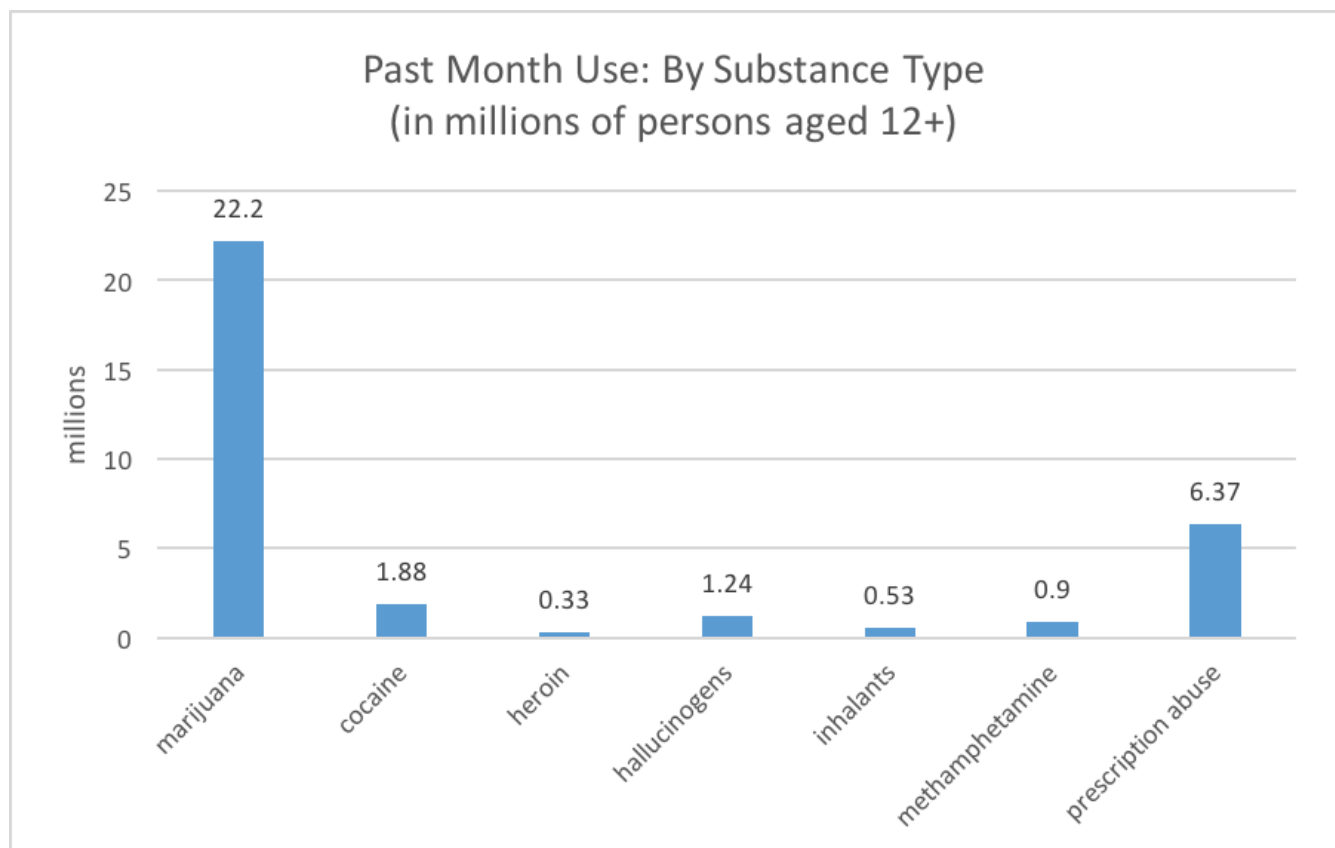
The **World Health Organization (WHO, 2014)** has identified alcohol as a significant factor in global disease (and death) burden. The **harmful use of alcohol** is defined as:

*drinking that causes detrimental health and social consequences for the drinker, the people around the drinker and society at large, as well as the patterns of drinking that are associated with increased risk for adverse health outcomes (p. 2).*

According to the WHO report, the harmful use of alcohol is associated globally with an estimated 3.3 million deaths annually.

In comparison, an estimated 27 million individuals (about 10.1 percent of the population) aged 12 and over used illicit (illegal) drugs during the surveyed month. The type of illicit drug most often used, by far, was marijuana (see Figure 2). The next most common was the misuse of prescription psychotropic drugs. Less commonly used were cocaine, hallucinogens, heroin, and methamphetamine.

Figure 2. Past month use of various substances (SAMHSA, 2016)



**Type of Substance by Age:** In the 2015 NSDUH survey (SAMHSA, 2016), patterns of alcohol and

illicit drug use can be calculated for each of the following age groups: 12-17 year olds (youth), 18-25 year olds (emerging adults), 26-64 year olds (adults), and those aged 65 and older. Technically, alcohol is an illicit substance for underage youths (those aged 12-17 in the survey), but for comparison purposes we will include those statistics with the adult drinking statistics. Figure 3 shows the percent reporting past month use of alcohol, binge drinking, and heavy drinking by age group. These numbers all peaked for our emerging adult group. Past month use of illicit drugs was highest among emerging adults (18-25 year olds), and within that adult group, the rate began a steady decline in percentage rate after age 26 (see Figure 4).

Figure 3. Patterns of past month alcohol use by age group.

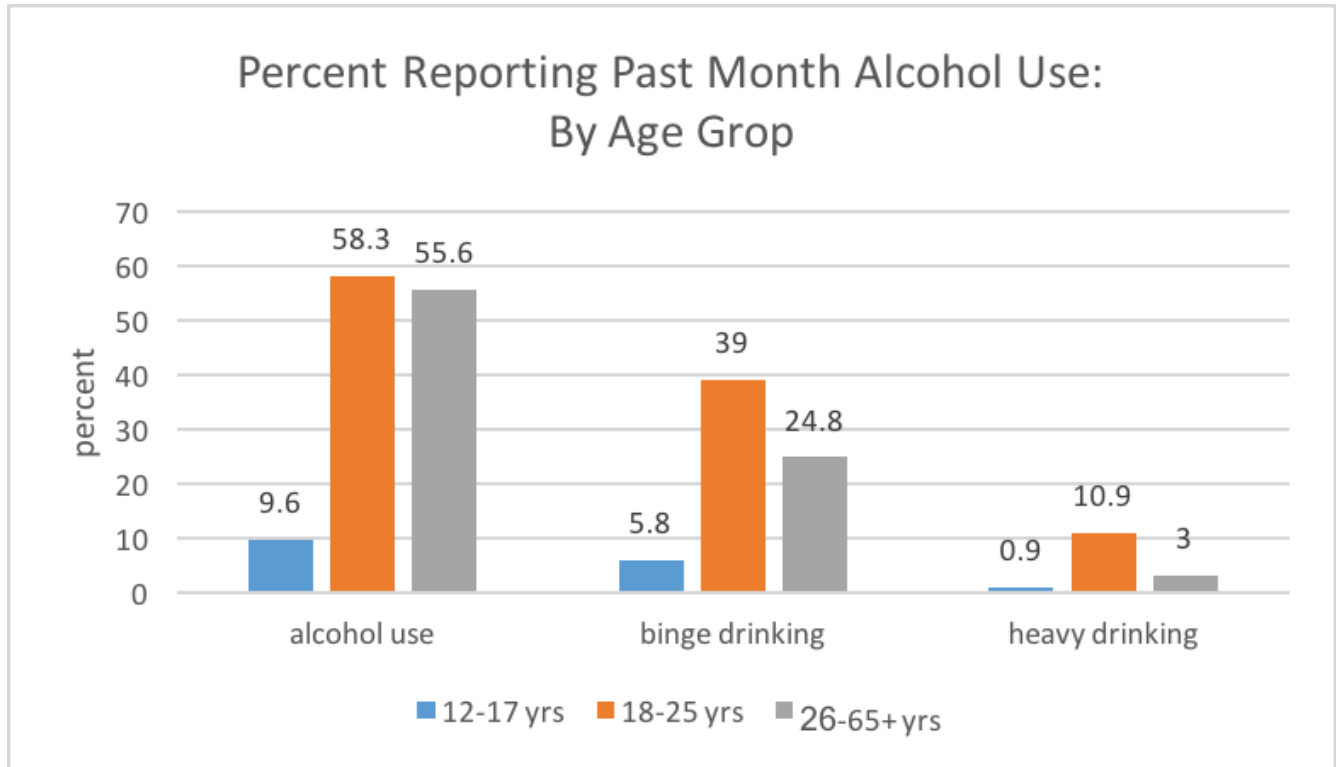
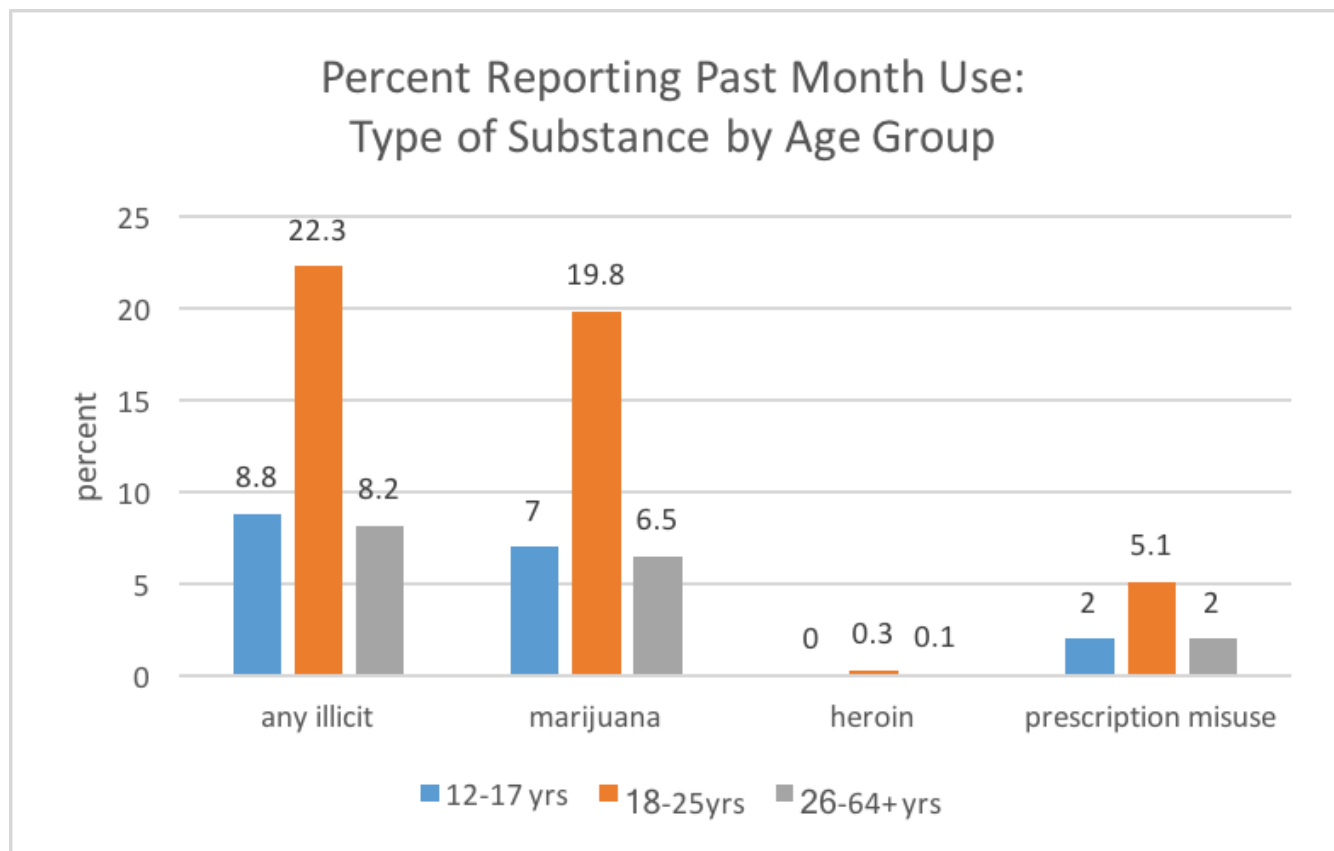
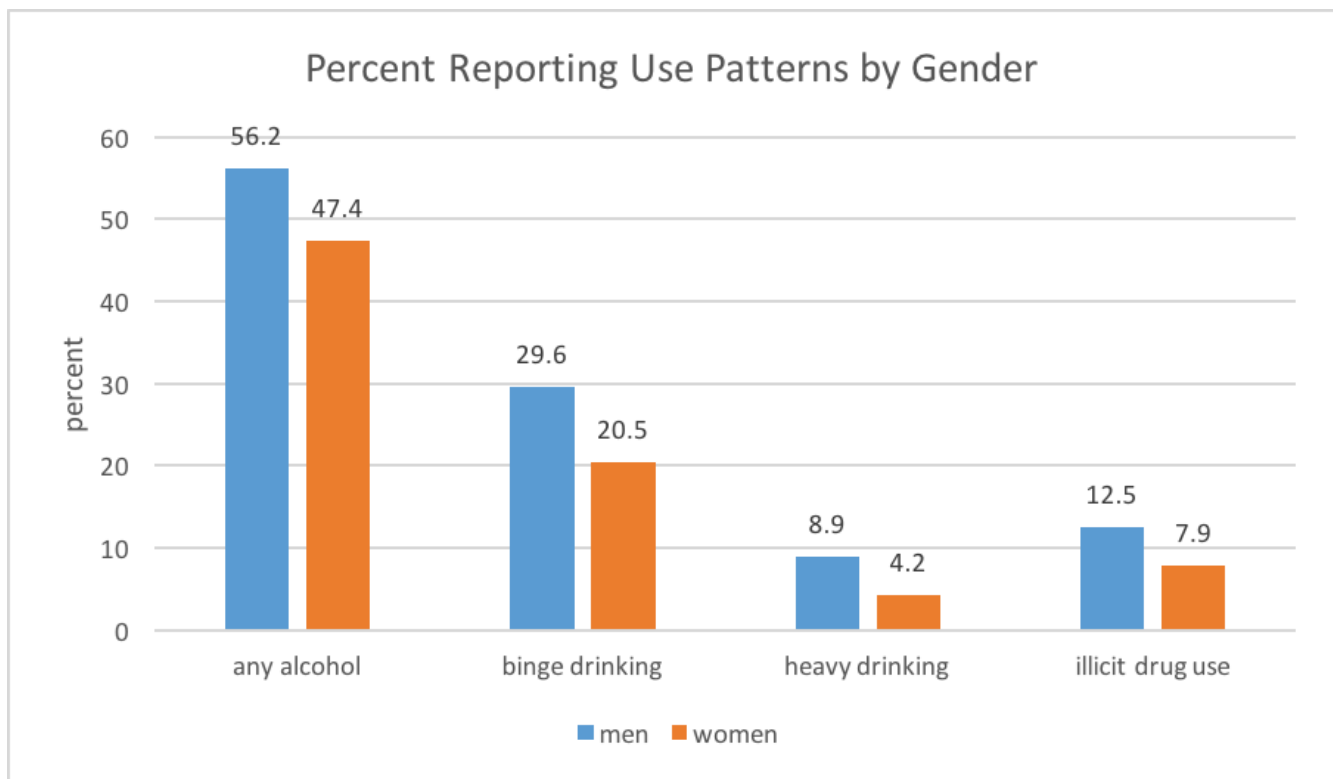


Figure 4. Patterns of past month illicit drug use by age group.



**Type of Substance by Gender:** Both alcohol and illicit drug use were more common among adult men than women (see Figure 5). This pattern of gender difference in illicit drug use was not observed among 12 to 17 year olds: the girls reported illicit drug use patterns similar to the boys in this age group (8.8%). The gender differences in illicit drug use first appeared among 18-25 year olds (emerging adults). However, among 12 to 17 year olds, higher percentages of girls (9.9%) than boys (9.3%) reported using alcohol; men drinkers outnumbered women drinkers among those over the age of 18, and potentially harmful patterns of drinking (binge and heavy drinking) were more commonly reported by men than women in the entire 12+ years sample (see Figure 5).

Figure 5. Drinking and illicit drug use past month patterns by gender for persons aged 12+ years



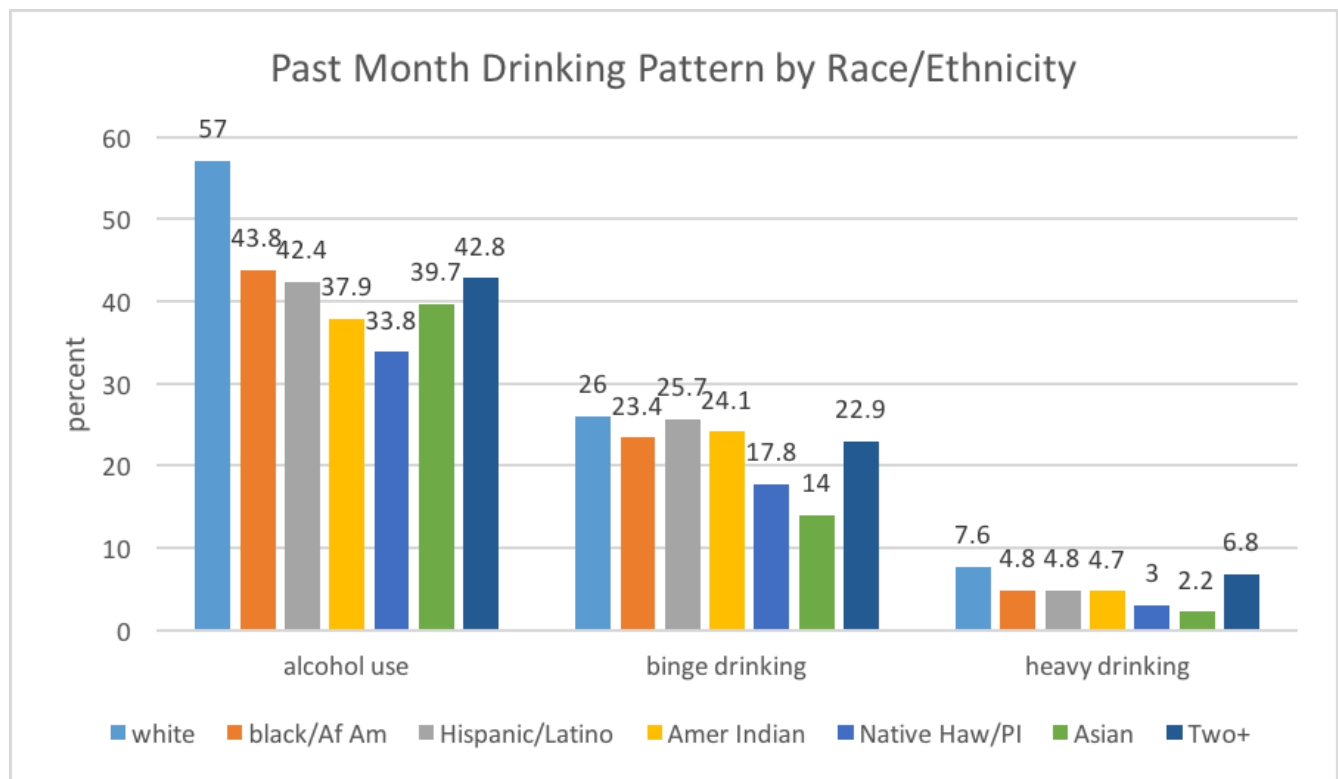
Of considerable concern are the findings that 9.3 percent of pregnant women reported using alcohol and 4.7 percent reported illicit drug use during pregnancy. This represents an unfortunately high rate of fetal exposure to these potentially damaging substances.

**Type of Substance by Race and Ethnicity:** The seven U.S. racial/ethnic groups for whom information is reported in the 2015 NSDUH survey include: white; black/African American; Hispanic/Latino; Asian; American Indian/Native Alaskan; Native Hawaiian/Other Pacific Islander; and, those who report being of two or more races.

The group most likely to report past month use of alcohol was comprised of individuals who identified themselves as white (see Figure 6), and the lowest rates were reported by Asian and Native Hawaiian/Other Pacific Islander groups. Looking at these statistics another way, the highest rates of drinking *abstinence* in the past month appeared among the Native Hawaiian/Other Pacific Islander and American Indian groups.

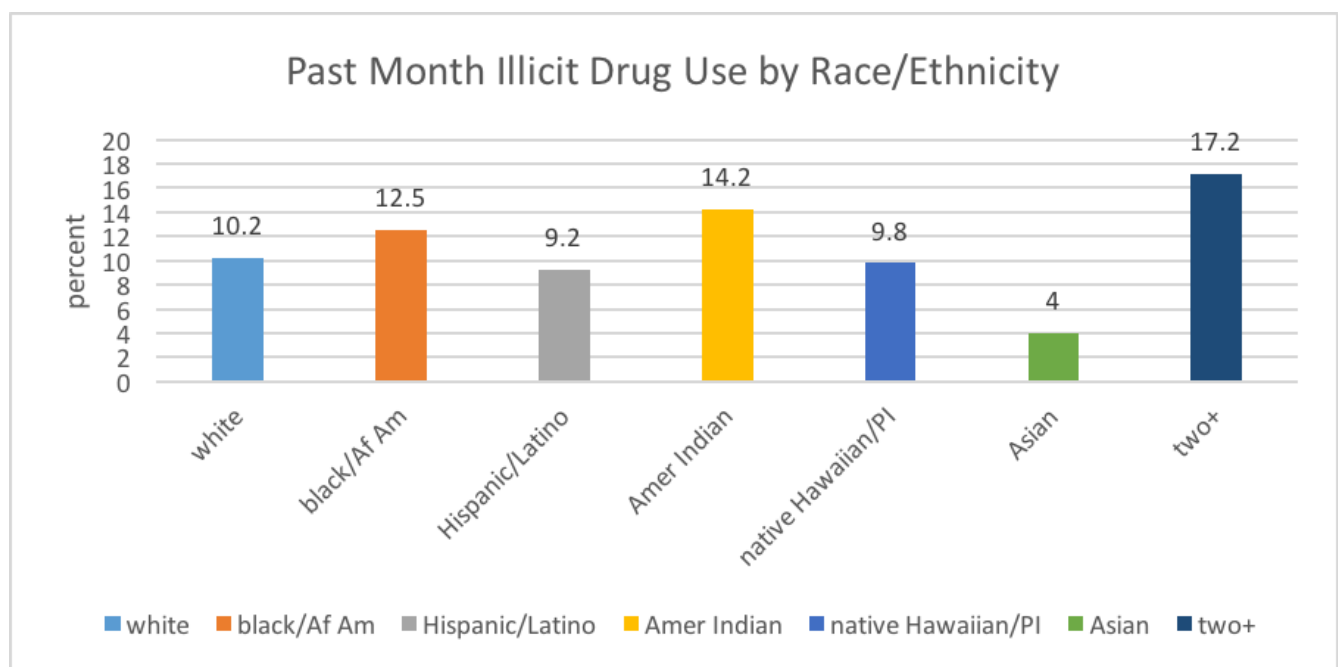
The picture is slightly different when looking at the binge-drinking pattern, however. The binge-drinking rate remained highest among individuals who self-identify as white, with the rate for Hispanic/Latino individuals being almost equal; those who self-identified as Asian had the lowest binge drinking rates. Heavy drinking, again, was at the highest rate among white individuals; somewhat lower and almost equal were the rates among Hispanic/Latino, black/African American, and American Indian individuals.

Figure 6. Past month drinking patterns reported by race/ethnicity



The group reporting the highest rate of past month illicit drug use was the group who self-identified as belonging to two or more races and the lowest rate was reported among Asian individuals (see Figure 7).

Figure 7. Past month illicit substance use by race/ethnicity





**Now that you have read the information, take a moment to compare what you learned as answers to the questions below with your pre-reading answers:**

- *What are the 2 or 3 most commonly used substances?*
- *What percentage of people aged 12 and older use each of those most common substances?*
- *What is the distribution of men versus women using these substances? • What age group is the highest user of these substances?*
- *What are the patterns of substance use among white, black, Hispanic/Latino, and Native American persons?*
- *What percentage of the population has a diagnosable substance use disorder?*

Were you surprised by any of the answers? What factors, information, or experiences do you think led you to guess the right or wrong answers?

## Ch. 3: A Brief History of Substance Use and U.S. Policy Responses

While many think of substance abuse as a contemporary social problem, the story of humans experiencing problems related to the use of psychoactive substances is at least 4,000-10,000 years old (Hanson, Venturelli, & Fleckenstein, 2015; Howard, Garland, & Whitt, 2013; Singer, 2012). United States history is peppered with documentation of problems associated with alcohol and other drugs. For example, the opiate drug known as morphine, widely used during the Civil War to manage wounded soldiers' pain, left many of them experiencing addiction as a result. Subsequently, heroin also became available and marketed as a “non-addicting opiate with greater analgesic potency than morphine” (Kornetsky, 2007, p. 96)! Prior to the Civil War, 60-75% of Americans who were addicted to opium or morphine were women, in large part because physicians often prescribed opiate drugs to deal with a wide variety of “female” complaints (Blumenthal, 1998). In addition, physicians of the time often prescribed alcohol as a treatment for opiate addiction, and many socially acceptable and widely accessible medicines contained very high alcohol or opium content (Plant, 1997; Straussner & Attia, 2002; van Wormer & Davis, 2013). See this historic advertisement.



**Early U.S. Policy and Legislation Efforts.** At around the end of the 19<sup>th</sup> century, awareness of potential

harms associated with these substances spread. For this and other political reasons, the United States Congress was encouraged to enact legislation to control opiate drugs, and passed the Harrison Narcotic Act of 1914. An added public policy motivation: governments could now collect special taxes on the production and distribution of these drugs. Some public policies advocated institutionalization in psychiatric and criminal facilities, while others enforced sterilization as part of the negative eugenics movement (White, 1998). These strategies were viewed as acceptable solutions to the problem of alcohol or other drug addiction as attempts to prevent its spread in the community (Straussner & Attia, 2002).

Since the Harrison Narcotic Act, the United States has implemented other criminalizing policy responses to alcohol and other drug problems. One familiar to most of us was the 18<sup>th</sup> Amendment—commonly known as Prohibition. This amendment to the United States Constitution banned the manufacture, sale, or transportation of “intoxicating liquors,” but not the drinking of alcoholic beverages.

Although the combination of the 18<sup>th</sup> Amendment to the United States Constitution and the Volstead Act (which clarified that beer and wine were included as alcoholic beverages) were implemented beginning in 1920, many states had already enacted their own more local prohibition laws (Hanson, Venturelli, & Fleckenstein, 2015; <http://www.archives.gov/education/lessons/volstead-act/>). The 21<sup>st</sup> Amendment repealed the federal alcohol prohibition laws in late 1933; some states and local jurisdictions were slower to change their own prohibition policies. Some states continue to have “dry” communities restricting the sale or distribution of alcohol, and some communities maintain “Sunday” or “blue” laws banning the sale of alcohol during certain hours. It was also during the 1920s and 1930s that many states developed prohibition-style policies about marijuana, and the federal government got involved in 1937 with passage of a Marijuana Tax Act and more severe criminalization policies during the 1950s.

You might find it interesting to pursue historical literature documenting the intersections of alcohol/drug policy with historical and sociological trends such as the temperance movement, women’s suffrage, immigration, organized crime, classism and racism (see for example, Straussner & Attia, 2002; van Wormer & Davis, 2013). Many of these historical policy patterns have implications for today’s politics and policy debates, as does the extensive economic impact of both local and international trade in substances such as alcohol, tobacco, coffee, tea, opium, cocaine, and others.

**Evolution of Contemporary U.S. Drug Policy.** During the 1960s, many programs and policies aimed at addressing both the supply and the demand sides of the drug trade were established. The term “*War on Drugs*” appeared in 1971, referring to stepped-up drug criminalization and law enforcement efforts (McNeece & DiNitto, 2012; Schori & Lawental, 2013). It is important to understand that while these programs focused on our internal drug problem, it is virtually impossible to separate our nation’s drug war efforts from international policy, international relations, and global economics. One criticism of “America’s Longest War” (the title of a 2013 award winning film) has great relevance to social work and disciplines concerned with social justice issues: the War on Drugs has contributed to extreme racial and gender inequities in the nation’s incarceration rates (Bush-Baskette, 1999; Chesney-Lind, 1997). For example, by the early 1990s, 74% of individuals serving prison sentences for drug possession were black, despite their accounting for only 13% of people who used drugs (Kilty & Joseph, 1999). The War on Drugs also may explain the relative explosion of women in prison for non-violent, drug possession charges that occurred during the late 1980s to 1990s—leading to a declaration that the War on Drugs became a “War on Women” (Bloom, Chesney Lind, & Owen, 1994). Another criticism of the War on Drugs addresses its high economic costs: over \$25 billion in fiscal year 2014 alone (ONDCP, 2014).

*Pregnant Women and Substance Use.* States differ in their policy responses to the use of alcohol or other drugs by women during pregnancy. For example, in some states a pregnant woman can be involuntarily committed to a treatment facility, jail, or relative's home for supervision to prevent her continued use of substances known to be harmful to a developing fetus. Many states have policies relating to the substantiation of child maltreatment allegations when a pregnant mother misuses alcohol or other drugs. While intended to help protect the unborn child from potentially harmful drug exposure, these policies are controversial, as they also may discourage women from seeking much-needed prenatal care for fear of discovery and becoming subject to consequences imposed through the courts and child welfare system.

*Drinking Age Legislation.* Drinking age legislation restricts drinking by persons under the age of 21 years to very specific circumstances. You may find it hypocritical that a person who is 18 years old and treated as an adult in all other domains may not be treated as an adult in this particular domain. Drinking establishments are certainly concerned about reduced revenue from not being allowed to legally serve alcohol to 18-20 year olds. On the other hand, there exists compelling evidence that higher drinking age minimums are associated with lower traffic fatality rates, for example. Another rationale involves an attempt to mitigate the potential risks associated with exposing the still-developing, emerging adult's brain to alcohol: major developmental changes in brain structure and function, beginning early in puberty, continue well into the period of adulthood (Spear, 2000). Furthermore, raising the legal age to be well over 18 eliminates confusion about enforcing alcohol-free zones in high schools which is one reason such a policy was supported by school administrators. Drinking age policy periodically becomes contested, tested, and retested in the United States. While this is policy determined at the state level, federal highway funding rules seem to govern the states' uniform decision to support a minimum legal drinking age of 21 years.

*Decriminalization Efforts.* Our nation has an opportunity to learn from the contemporary "natural experiment" in policy reform whereby several states have decriminalized the production, distribution, possession, and/or use of marijuana. Some hypothesize that *decriminalization* of substance possession or use might reduce the economic incentives for illegal production and distribution of drugs, and allow government entities to increase revenue through taxation (McNeece & DiNitto, 2012). Decriminalization is contested, however, as potentially contributing to increased rates of substance use disorders and other health risks associated with substance use: problems such as driving under the influence. Law enforcement professionals have expressed grave concerns regarding the potential for increased demands on police forces already stretched by the need to manage alcohol-related situations if marijuana is also legally used by the general public. Recent evidence suggests that the presence of legal (medical) marijuana dispensaries is associated with increased violent and property crime rates in adjacent areas (Freisthler, Ponicki, Gaidus, & Gruenwald, 2016). Addiction treatment providers have expressed concern about the potential impact of easier access on individuals already in recovery from substance use disorders, and the potential for further stressing an under-resourced treatment service system with an increase in demand for intervention to address problems with marijuana use. Prevention experts are concerned about the message that legalization/decriminalization might convey to young people considering initiating substance use. And, there continues to be controversy as to the potential (as yet, unknown) effects on the health care system resulting from an increase in disease or disability due to long-term use of marijuana products—along the lines of what we see with alcohol.

*Drug courts:* Traditional drug-control methods of the criminal justice system, such as mandatory incarceration and harsher penalties, along with court-mandated treatment following release from incarceration,

have not proven to be sufficiently effective to curb the problems associated with illicit drug use (Broadus, 2009). In addition, these efforts wreak havoc on the court system by creating tremendous backlogs of cases considered to involve relatively minor, non-violent offenses, and push jail populations far over capacity at great public expense. In response, a movement emerged late in the 1980s to establish special courts for managing nonviolent, drug-related cases. The drug court mission was to engage individuals in court-monitored, structured, evidence-supported treatment and divert them from being incarcerated if they complied with the individually-tailored treatment plan. Each program involves an interdisciplinary team of criminal justice and mental health professionals responsible for creating an individualized comprehensive plan for each program participant, and for monitoring participant progress. Failure to comply with the plan results in the court levying the traditional sentences for the original offenses.

*Harm Reduction Policies.* Some strategies and policy approaches are based on the principal that has come to be known as *harm reduction*. While the goal always remains reducing risk by ending high-risk behaviors (like misusing alcohol or other drugs), it is not always wisest to wait for risky behaviors to cease. Instead, it is often wiser to intervene in ways that reduce the potential risks, harms, and other negative consequences associated with the behaviors in the meantime. This harm reduction approach, derived from public health rather than criminal punishment motivations, aims to improve quality of life for individuals, families, and communities associated with the risky behaviors (Collins et al., 2012). Some examples include programs to prevent driving while under the influence of alcohol or other substances, while not necessarily stopping a person from drinking or using substances; clean needle and syringe exchange programs to reduce risk of exposure to blood-borne communicable diseases like HIV/AIDS and hepatitis; supportive housing for which abstinence is not an eligibility requirement. Another harm reduction strategy has recently emerged in many communities: programs for making available to first responders, friends, and family members an emergency pack for administering an opioid overdose reversal drug (naloxone or Narcan®) to save the lives of individuals who might otherwise die of an overdose before professional treatment is accessible. On one hand, harm reduction is viewed as being practical and humane. On the other, there are concerns that harm reduction is too “soft” on people who are breaking the law, that abstinence-only policies are necessary to motivate individuals to change their behavior, and that risk-reduction approaches do not do enough to stop substance use.

*Access to Treatment.* Improving access to treatment for substance use disorders represents another modern policy/advocacy front with great significance for social work and other human service professions. In Module 2 we will learn about the considerable gap that exists between the need for these services and the numbers of individuals (and families) able to receive them. The nation budgeted just over 10.1 billion dollars to prevention and treatment for fiscal year 2014, including Medicare and Medicaid funded treatment services, substance abuse treatment for veterans and current military service members (and families), and prisoner reentry initiatives (Office of National Drug Control Policy/ONDCP, 2014). Federal funding also currently assists health-focused centers and institutes in monitoring the nation’s substance use problems and in studying causal factors and potential solutions. These include the *Centers for Disease Control and Prevention (CDC)*, SAMHSA, and several institutes of the *National Institutes of Health (NIH)*, such as the *National Institute on Drug Abuse (NIDA)*, the *National Institute on Alcohol Abuse and Alcoholism (NIAAA)*, and the *National Institute on Mental Health (NIMH)*.

A person’s ability to engage in formal, professional treatment for these problems often depends on an ability to pay with insurance or self-pay dollars. One potential advantage of the Affordable Care Act (ACA) first implemented in the United States during 2013-2014 was the possibility of increased access to mental health and substance

use disorder treatment services for many individuals. With passage of the ACA, young people were allowed to remain on a parent's Medicaid plan until the age of 26 years, subsidies helped more people afford health insurance, annual and lifetime benefit limits and limits on number of visits for behavioral health services were eliminated, and behavioral health care became more affordable by ensuring co-pays could not be greater than those for physical health services. The ACA also helped protect insurability for individuals who have a pre-existing condition in their medical records; having a history of a substance use disorder would be a pre-existing condition necessitating protections, no matter how long the person has been in recovery. The federal Mental Health Parity and Addiction Equity Act of 2008 also helped regulate the health plan/insurance industry with regard to benefits for individuals with substance use disorders in their medical histories. Despite excitement over expanded coverage and protections, concerns arose regarding the treatment system's ability to meet the anticipated increase in demand: Do we have enough trained professionals to meet the experienced need?

At the end of 2016, the U.S. Congress passed two major pieces of legislation related to substance use and addiction. The first was the Comprehensive Addiction and Recovery Act (CARA) that provided legal status for many harm reduction strategies, such as increased access by non-physicians to naloxone for reversing an opioid overdose. However, CARA did not provide funding for these approaches. The second was the 21<sup>st</sup> Century Cures Act that provided federal funding to “accelerate the discovery, development, and delivery of 21<sup>st</sup> century cures” and other purposes (<https://www.congress.gov/bill/114th-congress/house-bill/34/text> ). In addition to ensuring specific funding for the NIH and Federal Drug Administration, the act provided funding for states with relatively high prevalence of opioid use disorders to develop their responses for addressing the opioid abuse crisis. This included prescription drug monitoring programs, prevention activities, health care provider training about best practices, supporting access to treatment programs, and other public health-related activities to address the identified crisis. The impact of policy revisions regarding health care coverage since the 2017 change in national leadership remains to be seen. The White House created the President's Commission on Combating Drug Addiction and the Opioid Crisis (March, 2017) with the mission of studying “the scope and effectiveness of the Federal response to drug addiction and the opioid crisis...and make recommendations to the President for improving that response” (<https://www.whitehouse.gov/the-press-office/2017/03/30/presidential-executive-order-establishing-presidents-commission> ). However, at the same time, the Office of National Drug Control Policy (ONDCP), a component of the President's Executive Office, is at risk of being significantly defunded by the year 2018.



## Thinking About Policy Issues

For each of the following topics, consider what evidence supports your position, and what evidence might counter your position.

- **Drinking Age Legislation:** What do you think about the current minimum legal drinking age policies in the United States? What do you know about policies in your own community regarding being a minor in possession of alcohol, driving while under the influence as a minor, and the provision of alcohol to underage minors? How might these issues apply to cigarettes, e-cigarettes, and other tobacco products?
- **Drinking or Drug Use during Pregnancy:** What do you think should be the state's policy response to women who use alcohol or other substances during pregnancy, and why? What are the social justice issues involved? What are the likely "real world" implications of implementing (or not) such ideas in practice?
- **Prohibiting versus Decriminalizing Policies:** Thinking about the historical policy called Prohibition, what are the parallels and differences with regard to policies restricting distribution and use of other substances like marijuana or opioids/heroin? Consider the effectiveness or ineffectiveness of public education strategies that involve "scare tactics" and "Just Say No" policy responses to preventing substance use initiation by young people—what worked and what did not, and for whom were these approaches effective and for whom were they problematic? Why do you think the problems were or were not solved this way?
- **Naloxone access policies:** Naloxone is not a cure for addiction, but the immediate life-or-death health crisis may be resolved if delivered in time. The wholesale price for a 3-dose administration (necessary for many individuals who use heroin/fentanyl combinations) can cost over \$4,200. Though the costs to an individual person or family member can be offset to between \$0-\$125 in some communities through donated doses, grants, and public funding, doses provided by first responders may or may not be offset. What do you think about policy allowing non-professionals in the community to obtain prescriptions for naloxone to use if they witness an opioid overdose? What about prescribing it to a person with a diagnosed opioid addiction, to carry for others to administer if needed? How do you feel about doing this for someone yourself (and perhaps conduct rescue breathing during the time it takes to work)? How do you feel about these costs affecting city/county/state budgets for first responders?

## Ch. 4: Considering the Language That We Use

At this point, you have developed a general “big picture” about the topic of our course: substance use, misuse, and addiction. Throughout Module 1 so far you have read about alcohol and other substance use. You may not have noticed the language used to describe individuals involved with these substances or who experience substance-related problems. For example, you did not read about “substance users,” you read about individuals who use substances.

Social workers and members of several other human service professions have long been aware of the importance of the way we use language and the deleterious consequences of applying labels to people. In places where you eventually seek additional information on our course topics you may find that many resources use stigmatizing labels and terms. Not only do labels tend to stereotype, stigmatize, and marginalize people, they also create a pessimistic mindset about the possibility for change. In the field of addictions, awareness about the harms associated with stigmatizing labels like “addict” or “alcoholic” are discussed with increasing frequency. As the field gradually becomes more conscious and aware of this problem in professional writing and speaking, it is important that we all become more conscientious about changing how we discuss the people involved with substances.

Getting us thinking along these lines is the purpose for your second assigned reading, Begun (2016), *Considering the Language That We Use: Well Worth the Effort*. In this final chapter for Module 1, you will read about the importance of paying attention to the language that we use in discussing and describing people who use substances and people who experience substance use disorders or addiction. You may notice in the reference list a similarly themed article by Broyles et al (2014) that may be of interest to you, as well. After reading the assigned article (click on the link below), remember to return here for the interactive exercises.



[Click here for a link to our Carmen course](#) where you can locate the assigned pdf file(s) for this chapter. You will need to be logged into our Carmen course, select Module 1, and proceed to the Coursework area. Under the Readings heading you will find a box with links to the readings for relevant coursebook chapters. Don't forget to return here in your coursebook to complete the remaining chapters and interactive activities.

When you are finished reading this brief article:

- Begin to practice ways of changing the language that you use. For example, start by simply identifying stigmatizing labels used by others when you are reading, listening to radio, television, or movies, and talking about social work issues in your classes or with friends.
- As a next step, think about creative ways of editing what you read or heard to remove the labels and describe people in terms of their experiences instead.
- Think about how this might make a difference in how these individuals are viewed and how they might view themselves as a result.



Here is an exercise for you to practice these new skills. Imagine that you are the instructor for our course. First, read this hypothetical student discussion board posting and identify the 6 places where the use of language is of concern. Just click on your choices (some may be two-word phrases, others are single words) and see how you did.

Now, think about how you would suggest rephrasing each of the six problems. Here is one possible

solution—many options exist! The point here is to practice the new skills related to the language that we use. Hopefully, you can better edit your own work before posting in our class discussions in the future.

I think that persons experiencing addiction should be able to benefit from treatment for pain, but health care professionals are worried about providing pain medications when there is a question about the actual need. It is kind of the same thing as giving alcohol to someone with an alcohol use disorder to make them feel better. People who misuse substances or have an addiction may believe their pain is worse than they can tolerate, but there may be alternative ways to effectively address pain that doctors and nurses can offer. Treating a person's pain should be done with caution when there is a history of experiencing a substance use disorder, but it should also be done with respect.

## Ch. 5: Summary

In the readings for Module 1 you read about:

- Seven major types of psychoactive substances;
- Epidemiological trends in the United States related to substance use and misuse—patterns of use of different types of substances, as well as patterns of use by three different age groups, men versus women, and by racial/ethnic group.
- Major historical and current trends in policy related to substance use and substance use disorders.
- Monitoring the use of language about people who misuse alcohol or other substances.

In addition, this module presented you with opportunities to challenge your thinking about several substance use and misuse topics. You are now well prepared to review the list of key terms introduced in these readings.



# Module 1: Key Terms

**abstinence:** restraining from consuming a particular substance.

**binge drinking:** In the NSDUH surveys, this is defined as five or more drinks on the same occasion on at least one day. The NIAAA definition is a pattern of drinking alcohol that brings a person's blood alcohol concentration (BAC) to or above the 0.08 gram percent (legal level for driving). Risky single occasion drinking (RSOD) is another term for describing this pattern of drinking. Discussed in greater detail in our course Module 8.

**blood alcohol concentration:** defined in terms of grams (weight) of alcohol per 100 milliliters of blood, for example 0.08 means 80 milligrams (.08 grams) per 100 milliliters (100 ml=1 deciliter, dL) blood, and can be estimated in breath or urine tests; discussed in greater detail in our course Module 8.

**cannabinoids:** substances that interact with cannabinoid receptors in the brain to affect neurotransmitter release, such as the compounds in cannabis (marijuana); the subject of our course Module 12.

**Centers for Disease Control and Prevention (CDC):** operating through the Department of Health and Human Services (DHHS) to protect America from health and safety threats, respond to health threats, and support communities in protecting health.

**decriminalization:** the act of repealing, removing, or reducing legal restrictions or criminal penalties associated with a previously illegal act.

**depressants:** substances that reduce (depress) one's state of mental arousal, stimulation, or anxiety, as well as slowing the rate of body functions; the subject of our course Module 9, but also includes alcohol (Module 8).

**dissociatives:** substance that induce a state of relaxation and calm by detaching the conscious mind from perception brain functions, including pain perception—which is why it can be used in medical anesthesia; discussed in our course Module 9.

**hallucinogens (psychotomimetics):** substances that induce distortions in the sensory system perceptions of reality (hallucinations); discussed in our course Module 12.

**harm reduction:** practical strategies for reducing negative consequences from substance use, may or may not involve abstinence.

**harmful use of alcohol:** the World Health Organization definition involves consuming alcohol in a manner “that causes detrimental health and social consequences for the drinker, the people around the drinker and society at large, as well as the patterns of drinking that are associated with increased risk for adverse health outcomes” (WHO, p. 2).

**heavy drinking:** Defined in the NSDUH surveys as a pattern of consuming five or more drinks containing alcohol on the same occasion, on each of five or more days in a month; discussed in greater detail in our course Module 8.

**inhalants:** chemically volatile substances producing vapors that can be inhaled, and have a psychoactive effect; discussed in our course Module 12.

**National Institute on Alcohol Abuse and Alcoholism (NIAAA):** an institute of NIH charged with supporting and conducting research on the impact of alcohol use on human health and well-being, and leading the nation’s efforts to reduce alcohol-related problems.

**National Institute on Drug Abuse (NIDA):** an institute of NIH charged with advancing science concerning the causes and consequences of drug use and addiction, as well as applying that knowledge to improve public health.

**National Institutes of Health (NIH):** comprised of 27 institutes and centers, operating through the U.S. Department of Health and Human Services to seek knowledge about the nature and behavior of living systems and application of that knowledge to health enhancement.

**National Institute on Mental Health (NIMH):** an institute of NIH leading research into mental disorders, as well as discovery in the science of brain, behavior, and experience toward the goal of prevention and cure of mental disorders.

**National Survey on Drug Use and Health (NSDUH):** an annual study sponsored by SAMHSA providing national and state-level data concerning mental health status in the United States, and the use of tobacco, alcohol, illicit drugs, and prescription drug misuse.

**opiates:** substances containing or derived from opium, reduce pain, and induce sleepiness; the subject of our course Module 11.

**opioids:** substances that mimic the effects and properties of opiates, but are synthetically derived (not necessarily containing opium); the subject of our course Module 11.

**psychoactive (psychotropic) substances:** These are substances that, when consumed, have a significant effect a person’s mental processes, mind, mood, and behavior.

**Substance Abuse and Mental Health Services Administration (SAMHSA):** the federal agency in the Department of Health and Human Services (DHHS) charged with leading public health efforts to advance the nation’s behavioral health and reduce the impact of substance abuse and mental disorders on communities.

**steroids (anabolic & androgenic):** manufactured substances that mimic the effects of the naturally occurring hormone testosterone; discussed in our course Module 12.

**stimulants:** substances that have the effect of increasing alertness, attention, energy, blood pressure, heart rate, and breathing rate; the subject of our course Module 10.

**War on Drugs:** the label applied in 1971 by President Nixon to a campaign of United States government policy actions directed toward controlling trade in illegal drugs.

**World Health Organization (WHO):** part of the United Nation's system, headquartered in Geneva, and leading global efforts to promote health and responses to global health concerns.

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