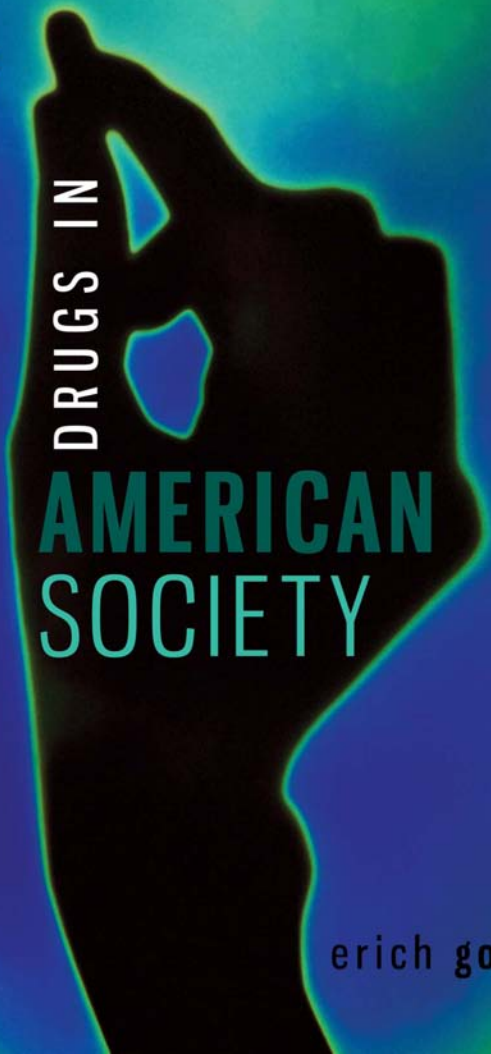
9th edition

DRUGS IN AMERICAN SOCIETY



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Ninth Edition

Drugs in American Society

Erich Goode

Stony Brook University

DRUGS IN AMERICAN SOCIETY, NINTH EDITION

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About the Author

Erich Goode is Sociology Professor Emeritus at Stony Brook University. He received his Ph.D. in sociology from Columbia University and a master's in nonfiction writing at Johns Hopkins, and has taught at Stony Brook, New York University, the University of North Carolina at Chapel Hill, and the University of Maryland at College Park. Goode is the author of 11 books, mainly on drug use and deviant behavior, including *The Marijuana Smokers* (Basic Books, 1970), *Between Politics and Reason: The Drug Legalization Debate* (St. Martin's Press, 1997), *Justifiable Conduct: Self-Vindication in Memoir* (Temple University Press, 2013), *Deviant Behavior* (Pearson Prentice Hall, 10th edition, 2014), and *Moral Panics* (with Nachman Ben-Yehuda, Wiley-Blackwell, 2nd edition, 2009). He lives in New York City with his wife, Barbara Weinstein, a historian who teaches at New York University.

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Preface

The first edition of this book was published before most of the readers of this edition were born—indeed, even before some of their parents were born. For the most recent editions, I've interviewed users about their consumption of substances that didn't even exist in 1972, and others who casually or compulsively use drugs that were virtually unknown at that date. The world today is a vastly different place than it was four decades ago and, more to the point, the current world of drug use and trafficking would be almost unrecognizable to a denizen of the early 1970s. To many of us now, the world back then seems almost alien, incomprehensible—archaic even; it was a landscape that was about to be hit by a series of social and political earthquakes.

In 1972, the United States was still waging a war in Vietnam that couldn't be won and, when they completed their service, thousands of GIs lugged tons of heroin back to eager junkies in America. The Cold War with the Soviet Union was in full swing; Russia and its satellite countries cracked down mercilessly on drug dealing. Generalissimo Francisco Franco's regime (Spain) likewise severely punished unconventionality in lifestyle, leftish politics, and the use and sale of illicit drugs. South Africa, an outsider nation boycotted by other countries, still practiced apartheid with an iron hand; the craniums of advocates of racial equality, radicals, and scruffy hippies who smoked pot made an acquaintance with police billy-clubs, and, in many cases, the inside of prison cells. Nixon, father of the War on Drugs and an advocate of a "law and order" position on crime, seemed to be firmly ensconced in the presidency; an almost accidental conjunction of events—which we now refer to as "Watergate"—was about to rudely unseat him and temporarily derail that selfsame war. Three separate police departments had just begun dismantling the French Connection—that heroin pipeline from Turkish poppy fields, through labs in Corsica, into the veins of American addicts—said dismantling ironically resulting in opening up a multitude of countries that supplied illicit drugs. Pol Pot, head of the Khmer Rouge, waged a war against his enemies, murdering more than a million of his own citizens in the process. Yugoslavia, an uneasy alliance among regions, was ruled by a dictator who, like the other despots, suppressed dissidence of every stripe. Personal computers were unknown, and the first email message had been sent just the year before.

Who knew that a tsunami of change was about to strike the globe? Authoritarian regimes that brooked no deviations from the law collapsed, morphing into democracies (or democracies *manqués*), which opened laissez-faire marketplaces to the hustle and bustle, the comings-and-goings, of capitalism, governments whose representatives technically criminalized drug trafficking, but inadvertently made it more possible—and likewise made prosecutions of drug dealings more difficult and facilitated communication and commerce and

the movement of vehicles and people across borders. The curtain opened wide onto a truly global age. Illicit drugs and other products—both legal and illegal—crossed borders as never before in human history.

Anyone attempting to chronicle these and other cognate changes and to elucidate and analyze the current state of affairs faces a daunting and challenging mission; I modestly set forth my effort in this edition. Drug use is an activity in which humans engage; it is socially patterned; it has important social consequences; drug users are looked upon, dealt with, judged, evaluated, and reacted to; and they, as well as their activity, are socially constructed in ways that demand investigation. Consequently, from the point of view of social theory—that is, devising general explanations of human behavior—the subject is very much in need of sociological consideration.

A study of drug use is also crucial from a policy standpoint. It is in fact, a life-or-death proposition. Drug abuse can kill. In addition, drug use, whether directly or indirectly, often spawns a swarming host of sub-lethal problems: disease, poor quality of life, enslavement to a chemical, lower academic and job performance, victimization by robbers, rapists, and all other manner of violent offenders, the fear by residents of a community for their safety, the fear of leaving their homes at night, and subversion of friendship, romantic, and family relations. In the United States alone, smoking claims over 400,000 victims a year—and gradually, in response to studies on the medical harms of smoking, year by year, smokers are giving up the deadly habit. While the consumption of alcohol kills some 85,000 Americans yearly, as a result of education and automobile and roadway innovations, alcohol-related highway deaths have been cut by two-thirds. The introduction of drug education curricula may have helped, so it's important to note that illicit drug use reached a peak in the 1970s—the decade of the publication of the first edition of this book—and has substantially moderated since then. Quite simply, systematic study of the causes and consequences of substance abuse can save lives.

Every edition of this book has represented an effort to teach students about the reality of drugs and drug use, as I interpret the available evidence. And in this effort, it is the evidence above all that guides my approach. Examining the facts and figures—statistics, if you will. Some students find scrutinizing statistics dull and sometimes confusing, but to me, a well-constructed table is informative—as well as a thing of beauty. Discussing the reality of drug use without having access to facts and figures—human behavior in its quantitative aspect—is like groping around in the dark.

But behind drug facts and figures, surveys and statistics, there is the human drama. People ingest drugs, for good or ill, and, as a result, they are dealt with by the rest of the members of the society, again, for good or ill. Real people's lives are affected in myriad ways by drug consumption and the enforcement of the drug laws, and the rest of us have to live with the consequences—or try to change the world so that these consequences are minimized or eliminated. The story of drug use, then, is the confluence of the hard, material facts of the consumption of psychoactive substances and the reactions to that consumption by the many actors in this drama, users and nonusers included. How we are all caught up in this confluence is the story I wish to tell in this book.

It's difficult to imagine a more fascinating topic: As a result of the interlock between the chemical structure of certain substances and human neurology, drug use alters the way we think, feel, and even act, and the way—how well, how poorly—our organs, including our brain, work; it influences the risks we take, what we attend to, our sense of empathy, whether we are caring or insensitive toward others, the workings of our imagination, our esthetic sense, our appetite, whether we are articulate or inarticulate, our degree of coordination, the state of our health, our likelihood of living or dying in the next year or two—or 50, 60, or 70. What a remarkable phenomenon! What a wondrous topic to study! What possibilities drug use research opens up! What a glorious time to be looking at the use of psychoactive substances! And

what discoveries lie ahead! I hope that this book conveys some of my enthusiasm for the subject.

ACKNOWLEDGMENTS

I owe a debt of gratitude to a multitude and diversity of people who helped me along the way to this edition's completion, as well as those who helped me put together earlier editions. I looked through the acknowledgments in past editions, and the list of the people who have helped me and to whom I am grateful is extremely long. Unfortunately, some of them are no longer with us, but my gratitude remains. All of them, taken together, include Patricia Adler, Paul Attewell, Stephan Barr, Nachman Ben-Yehuda, Gina Bisagni, Nancy Blaine, Zhanine Brooks, Jennifer Brown, Elof Axel Carlson, Paul Chalfant, Stephen Chappell, James Colliver, Stephanie Compos, Elizabeth Crane, Julie David, Dale Deutsch, Lisa Castelluzzo Dolan, Nancy Duckworth, Diane Eidelman, Kathryn Ann Farr, Laura Franz, Tricia Fuentes, John Fuller, John Galliher, Avram Goldstein, Lester Grinspoon, JoAnn Grundbaum, Maris Hearn, Clare Imholtz, James Inciardi, Eric Jensen, Bruce Johnson, Robert Keel, Paula Holtzman Kleinman, Jerome Koch, Marvin Krohn, Laura LaPiana, Henry Lesieur, Alfred Lindesmith, William McAuliffe, Charles McCaghy, David McCandlish, Jacqueline McFadden, Iona Man-Cheong, Arthur McBay, Patti Meyer, Judith Droitcour Miller, Ethan Nadelmann, Diane Reznikov, Marsha Rosenbaum, Terry Rosenberg, Alphonse Sallett, Mark Segal, Nathan Sevin, Linda Silber, Maura Strausberg, John Talbott, Al Woodward, and Joanna Yoon.

In addition, I owe a debt of gratitude to Alexia Cooper, Howard Snyder, and Joseph Mulako-Wangota for supplying me with the material which I adapted to create the table that appears in Chapter 2, on drug arrests.

I'd also like to thank my former students, especially those who have taken the courses I've taught that deal with drug use, from whom I have learned so much over the years. In addition, all the researchers who have studied drug use and attempted to unravel its mysteries and contradictions receive my profoundest appreciation. I'd also like to thank the anonymous drug users and sellers who provide the illustrations and accounts that enliven this text, as well as the anonymous readers of an earlier version of this book, who have reminded me of my obligations as a writer, a communicator, and a teacher, to make its prose clear and its discussions comprehensive. Finally, I would like to thank the reviewers of this edition, who include Carl Maida, California State University, Northridge; William Price, North Country Community College; Robert Keel, University of Missouri–St. Louis; Michael Ostrowsky, Southern Utah University; and Michael Bisciglia, Southeastern Louisiana University.

What husband does not thank his wife? I owe a debt of gratitude to Barbara Weinstein, who held my body, soul, and spirit together while I revised and rewrote this book.

ONLINE INSTRUCTOR RESOURCES

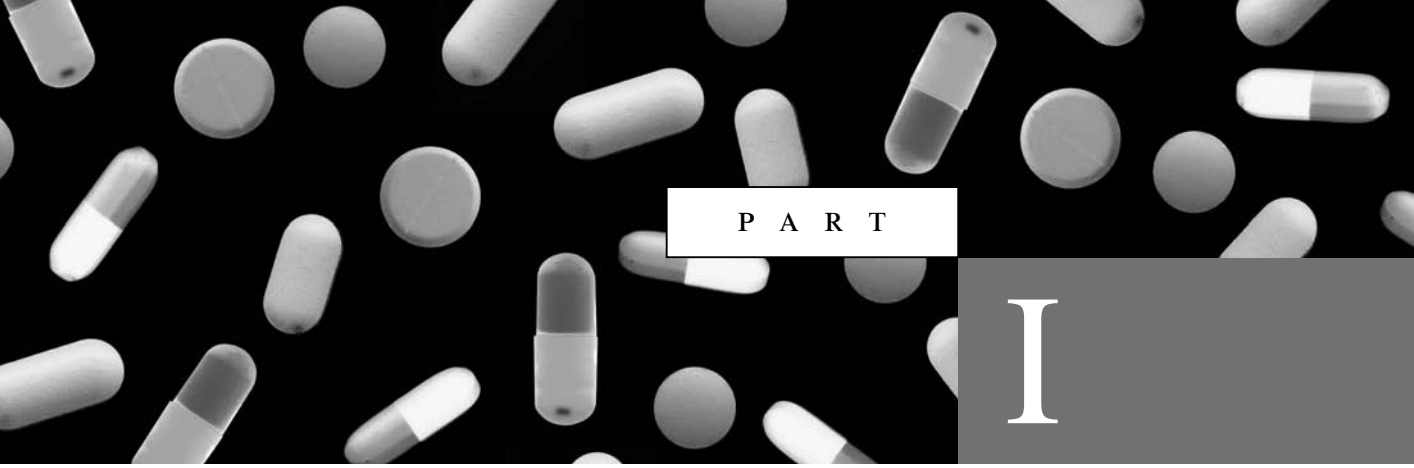
The Online Learning Center to accompany *Drugs in American Society* offers a number of additional resources at www.mhhe.com/goode9e. Instructor can access to an Instructor's Manual, Testbank, and PowerPoint lecture slides. Please contact your McGraw-Hill Learning Consultant for access information.

NEW TO THIS EDITION

At the suggestion of some of the readers of the previous edition of this book, I radically reordered the chapters that appear in this volume. Several critics thought that the historical background of drug use and drug control should provide a background to the current picture, and so the previous Chapters 5 and 12 became Chapters 1 and 2; consequently, the former Chapters 1 and 2 became 4 and 3. Reconceptualizing the media's view of drug use as a perspective on the issue, I grouped the

former Chapter 3, now Chapter 5, with the pharmacological and the sociological approaches. Chapters 6 and 7, formerly 4 and 6, form a natural grouping of their own. I kept the remainder of the book more or less as it was. I moved the former Chapter 8, on prescription drugs, to Chapter 9 in this edition. This made sense with respect to arranging topics in order of degree of illegality, so that the progression moves from completely legal recreational drugs (alcohol and tobacco) to prescription drugs (completely legal if taken for medical and psychiatric ills, with a physician's prescription) to mostly illegal but semitolerated recreational drugs if possessed in small quantities, to completely illegal drugs. In Chapter 3, I added a section discussing PCP and ketamine, the disassociative anesthetics, and in Chapter 2, I added a section, entitled "The Legacy of the Nixon/Reagan Years," that summarizes the drug laws as an outcome of contemporary politics. From the former Chapter 2 (now Chapter 3), I deleted the section on years of potential life lost (YPLL) as not directly relevant to pharmacology, and incorporated discussions of the concept into the text. From the former and present Chapter 10, I deleted the "Poison in a Glassine Envelope?" since it did not contribute directly to the chapter's main points. And everywhere relevant and appropriate, I have thoroughly updated the facts, figures, and illustrations in the text for this, the ninth edition of *Drugs in American Society*. I hope the changes I've made have succeeded in making this text smoother, more readable, more interesting, and more informative.

Erich Goode—
Greenwich Village, New York City



PART

I

A History of Drug Use and Drug Control

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CHAPTER 1

A History of Drug Use

Did alcohol consumption increase during Prohibition? No; actually, it decreased—though when I ask this question in a true-false quiz, most of the students in my classes think otherwise. Is alcohol consumption in the United States at an all-time high? In fact, it is at a fairly low point compared with most other periods of history. Did drug

use increase during the 1980s? No, it decreased dramatically during that decade. Was LSD consumption at an all-time high during the 1960s? No, data show it was quite low during the first half of the 1960s; it rose only in the second half of that decade, and peaked (for high school seniors) in the 1990s. When someone spends a major part of a lifetime studying and writing about a topic, it's discouraging to discover that most people hold an inaccurate picture of what one is trying to understand and communicate. Aside from simple ignorance, there are psychological and cognitive reasons why people often reason about the world in mistaken and inaccurate ways. Many people have a difficult time thinking clearly and accurately about drug use. They exhibit so many sources of error in their thinking processes that it would require an entire library to discuss them all. Focusing specifically on claims the government makes, Matthew Robinson and Renee Scherlen, two Michigan State University scholars, published a book that says it all: *Lies, Damned Lies, and Drug War Statistics* (2007). Much of the public falls victim to these "lies."

Frequently, the media, politicians, social movement activists and advocates, and the general public make incorrect inferences about social phenomena as a result of a faulty understanding of empirical rates, patterns, and statistics. In Chapter 5, we look at how the media report the drug beat. And I discuss the mistaken views of the public, politicians, and movement activists pretty much throughout this book. Certain social constructions of the reality of drugs, as well as the actions based on them, have had undesirable—even disastrous—consequences, yet they have guided public opinion and drug policy for more than a century.

The public bases its notion of the frequency of behavior not on logic or systematic evidence but largely on "rules of thumb" that are both commonsensical and illusory. Cognitive psychologists, who study how people think and reason, refer to these rules of thumb as *judgmental heuristics*. They have located and documented several distinctly different sources of bias. For the sociologist of drug use and the criminologist, perhaps the most relevant of the judgmental heuristics that distort our reasoning ability is the *availability heuristic* (Kahneman, Slovic, and Tversky, 1982, pp. 163ff).

"Availability" is a mental process that mistakenly tells us that what sticks in our minds is more common than something that takes more effort to recall; people tend to exaggerate the frequency of phenomena that come readily to mind. Since things that do not easily pop into our heads tend to be quickly forgotten, most of us underestimate their frequency. Our minds work in almost precisely the opposite way from the way the world works. The mundane, the everyday, and the ordinary—what is usually very common—are taken for granted and so are conveniently forgotten, while the spectacular, the vivid, and the unusual, because they are so easily recalled, are frequently mistakenly thought of as more common than they actually are.

Vividness is an especially powerful factor in the availability heuristic: People tend to recall what's vivid and dramatic, and they usually mistakenly believe it to be more common than it actually is. For instance, as study after study has shown, people tend to overestimate the likelihood of dramatic, memorable events, such as a shark attack (versus drowning); contamination from a nuclear plant (versus natural radon contamination from the soil); interracial crime—crime that crosses racial categories (versus *intra*-racial crime, or crime in which the offender and the victim share the same race); murder (versus more ordinary causes of death, such as pneumonia); and drug overdoses (as opposed to chronic death due to tobacco- or alcohol-related causes). In each case, the principle is the same:

Events that are dramatic and vivid tend to stick in one's mind and thus be "available" for recall and, as a consequence, their frequency or likelihood of occurrence tends to be exaggerated. Whenever we think about vivid, dramatic phenomena such as drug use and crime, we should keep the availability heuristic in mind. Doing so will help keep our observations on track.

RATES AND PATTERNS OF DRUG USE: THE BASICS

Here are four crucial concepts or ideas essentially to understanding rates and patterns of drug use: overall prevalence rates, continuance or "loyalty" rates, consumption levels, and life-cycle rates. They provide baselines which allow us to compare use from one period of history to another.

Overall Prevalence Rates

It is important to distinguish between and among rates of different drugs and drug types. Many commentators discuss illicit drugs as if the use of each and every one were precisely equivalent. Different drugs attract users at substantially variable rates. The *prevalence rate*—the number and percentage of people in the population who use a given drug during a designated period—is crucial; we must never lose sight of the *size* of a given drug's user population. Hence, when the 2011 national household survey [National Survey on Drug Use and Health (NSDUH)] reported that 7.0 percent of the population had used marijuana at least once during the previous month, while 0.5 percent had done so for cocaine, these are *prevalence* rates for that month for these two drugs. We could measure prevalence rates by lifetime, past year, or past month (or 30-day) use.

Journalists have been known to exaggerate the shifts in drug use from one decade to another, claiming that a particular drug is the "drug of choice" during each period. Supposedly, LSD was *the* drug of the 1960s—the implication being that it was the most frequently used drug during that decade. The same was said of cocaine during the 1980s (the so-called "me" or *greed* decade). In 2008, *Newsweek* decided that prescription drugs were teenagers' "drug of choice." In 2012, the *New York Post* reported that Xanax was becoming the addict's "drug of choice." In 2013, *New York Magazine* disclosed that modafinil was Wall Street's "drug of choice." These declarations make good copy, but we have to verify them empirically; we need to distinguish between the drug that *commentators* say is typical, characteristic, or paradigmatic of a period and the drug that *evidence* says is actually used most frequently.

The first observation we could make about overall prevalence rates of drug use in America—one that hits us like an onrushing avalanche—is the huge difference in the prevalence of the use of *legal* versus *illegal* drugs. In 2011, only 22.5 million Americans age 12 and older, or 8.7 percent, were "current" users of any illicit drug—they took one or more illegal drugs one or more times in the 30 days prior to the survey. But in that same year, there were 133.4 million current users of alcohol and 68.2 million last-month users of cigarettes. Alcohol and cigarettes—the legal drugs—are used by *vastly* more people than all the illicit drugs added together. "Not among my crowd," a skeptic might say. "Who cares?" the empiricist would retort; "your crowd may be atypical. And besides, where's the evidence?"

Alcohol is by far the most popular of all psychoactive substances. This has been true for at least a century, is true now, and, in all likelihood, will remain true a century from now. Moreover, it is true globally as well. In 2011, half the American population age 12 or older (52%) took at least one alcoholic drink in the past month; 8 in 10 (roughly 80%) consumed alcohol one or more times during their lives. The sheer number and percentage of people who use alcohol means that this drug's entanglement in activities of all kinds, including criminal behavior, is likely to be considerable.

Of all *illicit* drugs, marijuana is the one used by the greatest number of people—and by a considerable margin. In 2011, 4 out of 10 Americans (42%) said that they had used marijuana at least once in their lives; roughly 1 in 9 (11.5%) had done so in the previous year; and about 1 in 14 (7%) had done so during the prior month. Cocaine, the illicit drug with the *next*-highest incidence rate, racked up figures of only 14, 1.5, and 0.5 percent, respectively. Marijuana is the illicit drug that attracts the largest number of users—by far. There is no close competitor. The majority of people who use an illicit drug, use marijuana; the number of instances of marijuana use is greater than the number for all other illegal drugs combined. This has been true for decades and, in all likelihood, it will remain true for decades to come.

However, it's also true that some of the drugs that are used by relatively few people generate an enormous volume of social and personal disruption, including a great deal of criminal behavior. Two such drugs are heroin and crack cocaine. In the NSDUH, heroin ranks last in lifetime popularity, having ever been used by only 1.6 percent of the population and, during the past month, by a minuscule 0.4 percent. Crack cocaine is also used by a very small proportion of respondents—3.2 percent ever, and 0.1 percent during the past month. If NSDUH had access to prison and homeless populations, and if we had a sure-fire way of obtaining completely honest answers, the heroin and cocaine figures would no doubt be substantially higher. But no matter what information we manage to obtain, compared with other drugs, some substances are used by relatively few people, yet have huge repercussions in terms of criminal activity and the criminal justice system—and heroin and crack are two such drugs. In any examination of drugs and crime, we have to make a sharp distinction between rates of use and social impact.

Continuance or "Loyalty" Rates

We've taken a brief look at the "loyalty" or continuance rates of different drugs; let's look at this phenomenon in a bit more detail. The number of people who have used a given drug is less important than the number and proportion that use it *regularly*. *Continuance rate* is one of the most important features of a drug's pattern of use. Drugs vary with respect to user "loyalty": Users stick with some drugs longer than others. People tend to give some drugs up after experimental use; they tend to use others over a long period of time but episodically, sporadically, on a once-in-a-while basis, while they use a few more on a regular, even frequent, basis.

Of all drugs, licit and illicit, alcohol generates the strongest or greatest user loyalty. And of all *illegal* drugs, marijuana—the most frequently used and least associated with a "deviant" image—generates the strongest user loyalty. Of the many factors that determine a drug's continuance rate, perhaps the legal-illegal dimension is the most influential. As a general rule*, legal drugs have higher continuance rates than illegal drugs*. In spite

of some observers' claims, illegal drugs are not as easy to obtain as alcohol and cigarettes. There is a certain "hassle factor" involved in obtaining them; they are considerably more expensive, and obtaining them entails a risk of arrest. As a result of the hassle—coming up with the money, locating a dealer, and risking arrest—illegal drugs are much more likely to be given up or are used much more infrequently and sporadically than are legal drugs.

How are rates of drug use continuance measured? One way is to compare lifetime use with use in the past month. Picture a large circle representing all the people who have ever used a given drug, even once, during their lifetimes. Then picture within the large circle a smaller one that represents the number of people who have used that drug within the past month. If the smaller circle is a substantial proportion of the larger circle—if most of the people who ever used a given drug are still using it—then that drug generates a *high* continuance rate; its users are relatively loyal to it. On the other hand, if the inner circle is much smaller than the outer circle—if most of the people who ever used a given drug are no longer using it, or used it the last time a long time ago—then the drug's continuance rate is low, that is, its users are not very loyal to it.

Let's look at the actual loyalty or continuance rates (see Table 1-1). Of all "at least one time" users of alcohol, slightly less than two-thirds (63%) drank in the past month. Slightly more than a third of the people who smoked cigarettes once or more in their lives (35%) smoked them within the past month. Of the illegal drugs asked about in the 2011 NSDUH, marijuana—as we saw, considered the least "illicit," least deviant, and

TABLE 1-1 Continuance or "Loyalty" Rates, Selected Drugs 2011

	Month-to-Lifetime			Month-to-Year	
	Ever Used	Used in Past Year	Used in Past Month	Continuance Rate	Continuance Rate
Alcohol	82.2	66.2	51.8	.63	.78
Cigarettes	62.7	26.0	22.0	.35	.85
Marijuana	41.9	11.5	7.0	.17	.61
Cocaine	14.3	1.5	0.5	.03	.60
Pain Relievers	13.3	4.3	1.7	.13	.40
LSD	8.9	0.3	0.1	.01	.33
Tranquilizers	8.4	2.0	0.7	.08	.35
Ecstasy	5.7	0.9	0.2	.04	.22
Methamphetamine	4.6	0.4	0.2	.04	.50
Crack	3.2	0.2	0.1	.03	.33
Sedatives	2.9	0.2	0.1	.03	.50
PCP	2.4	0.0	0.0	**	**
OxyContin	2.3	0.6	0.2	.09	.33
Heroin	1.6	0.2	0.1	.06	.50

Note: Not all categories are mutually exclusive; some categories are included in others.

Source: National Household Survey on Drug Abuse: Detailed Tables, 2011, SAMHSA, 2012.

least criminal of the illegal drugs—generated a 17 percent continuance rate. (Keep in mind not only the drug but also the route of administration: Cigarettes and marijuana are smoked, while alcohol is taken orally.) In 2011, heroin and crack cocaine, the most serious and the least popular—although in principle the most dependency-producing—of the illegal drugs, manifested continuance rates of 3 and 6 percent, respectively. LSD, a drug that is characteristically used extremely sporadically, generated a continuance or loyalty rate of only 1 percent. This same pattern—the legal drugs displaying much higher continuance rates than illicit substances—prevails in the Netherlands (Sandwijk, Cohen, and Musterd, 1991, pp. 20–21, 25) and, as far as drug researchers are able to determine, everywhere else as well.

A somewhat different continuance rate can be obtained by comparing the use of a given drug in the past *year* with use in the past *month.* As measured by this particular indicator, the drug with the highest continuance rate is the nicotine in tobacco cigarettes; in the year 2011, 85 percent of all people who smoked during the past year also smoked during the past month. Measured this way, 78 percent of alcohol drinkers continued to take their drug of choice, as did 61 percent of marijuana users, and 60 percent of cocaine users. By this measure, among the illicit drugs, marijuana and cocaine attract more than half of their users on a monthly-to-yearly basis; they are the most regularly used of the illegal drugs. And while many more people drink alcohol than smoke tobacco, the people who *do* smoke cigarettes do so a great deal more often and more continuously and regularly than drinkers consume alcoholic beverages. The typical pattern of regular cigarette smoking is *chronic* use, whereas for current drinkers, the most typical pattern is *moderate* use.

For illicit drugs, "at least one time" lifetime users divide into quitters, sporadic or less-than-monthly, and monthly-or-more users. For most illicit drugs, daily use tends to be extremely atypical. But for alcohol, it is common, and for cigarettes, it is the rule among those who continue using. While *most* persons who try an illicit drug give it up after experimentation, a substantial minority continues using right up to the present time—but a minority nonetheless. Marijuana and cocaine are the only illicit substances a majority of whose last-year users continue use to the present—as we saw, 6 users in 10. But to repeat, for the legal drugs, a *majority* of last-year users have also taken the substance within the past 30 days. In short, *the more deviant, unacceptable, illicit, and illegal the drug, the more users discontinue its use, or use it sporadically; the more conventional, acceptable, licit, and legal the drug, the more users continue its use and take it regularly*.

Consumption Levels

Continuance rates lead us into another measure of use: *consumption levels*. A given drug may be widely used (prevalence rate) but not necessarily heavily used by those who take it (consumption level). During a particular year, there may be many casual, recreational users (prevalence rate) and very few heavy, chronic users (consumption levels). For instance, from the late 1970s to the early 1990s, prevalence rates for a number of illicit drugs (heroin and cocaine included) declined sharply but consumption levels remained high, because the number of heavy, chronic users remained fairly stable during this period of time, and most of the total quantity of drugs that is consumed is taken by the small minority of the very heaviest users. It is important to make this distinction because many

observers who comment on policy changes (such as legalization) confuse prevalence rates with consumption levels. As we'll see, legalization is more likely to influence consumption levels (the quantity of drugs consumed, mostly by the heaviest users) than prevalence rates (the number of individuals who use drugs).

Here's a good example of the difference between prevalence rates and consumption levels. In the United States, as we've seen, far more people drink alcohol than smoke tobacco cigarettes; the 30-day prevalence rate for alcohol is more than 15 percentage points higher than it is for cigarettes—52 versus 35 percent. But the *total consumption* of cigarettes is much higher than that of alcohol. More individual cigarettes (or "doses") are consumed than alcoholic drinks. The U.S. Department of Agriculture estimates that during 2011, the 57 million smokers in the United States consumed slightly more than 300 billion cigarettes or "doses" (in Chapter 8, take a look at Table 8-9)—about 15 cigarettes a day per smoker. According to the NIAAA (National Institute on Alcohol Abuse and Alcoholism), in 2010, drinkers in the United States consumed 2.26 gallons of absolute alcohol, or about 290 ounces, per year for the population age 15 and older, or the equivalent of roughly 1.6 ounces of alcoholic beverage containing 45 percent alcohol per day—the equivalent of about two drinks per day per drinker. (Of course, if the drinker consumes wine or beer, the figures are correspondingly higher, since these drinks are less potent.) While alcohol is the drug that is consumed by far by the greatest *number of people*, tobacco (which contains nicotine) is the drug that is used the greatest *number of times*. But keep in mind, too, that cigarette consumption has *plummeted* since the 1960s, while alcohol consumption has wobbled up and down in this country for over two centuries, that is, since the government has kept records of its sales. We'll take a closer look at alcohol and tobacco consumption in more detail in Chapter 8.

Consider, too, the difference between cocaine and heroin in prevalence rates versus consumption levels. Cocaine is a widely used intoxicant; during 2011, according to the national household survey, 3.86 million Americans used cocaine. In contrast, 620,000 used heroin during that year. However, again, remember that the NSDUH does not include the homeless or the prison population. In 2001, a research organization, Abt Associates, in an attempt to get around the homeless and prison population problem, estimated 900,000 chronic heroin users for the United States. Either way, cocaine has significantly higher prevalence rates than heroin. But far more striking is the difference between the consumption levels of cocaine and those of heroin. In terms of the *total amount consumed*, according to the Abt Associate's report, *What America's Users Spend on Illegal Drugs*, cocaine is used *nineteen times* more than heroin—259 tons versus 13.3 tons. (Since drug use in the United States has moderated somewhat, these figures would reflect this change.) In sum, the regular cocaine user consumes a greater volume of his or her drug than the regular heroin user does, whose use is more sporadic and episodic. Hence, an understanding of total consumption levels is crucial to getting a sense of levels of drug use. *How much* of a given drug is used is not the same thing as *how many* people use it.

Life-Cycle Rates

From time to time, the media report that drug use has become uncharacteristically high among an age segment of the population not typically given to high rates of use. For example, we read or hear that drug use is "common," "rampant," or "epidemic" among

11- or 12-year-olds, among the middle-aged, or even among the elderly. If true, this would be news. Apparently, even when it is not true, it's news anyway.

In spite of slight variations, wrinkles, and wiggles in this picture, for at least four decades, drug use has been, and remains, relatively low among youths (ages 12–17), extremely high among young adults (ages 18–25), even lower in the older adult years (ages 26–34), and lower still after the age of 35. (Of course, drug abuse among the very young is far more problematic, harmful, and disruptive than it is among young adults and the middle-aged sectors of the population.) Practically no study has found a higher rate of recreational drug use among young adolescents than among older adolescents and young adults. In all likelihood, this will remain true for a number of decades to come. (An obvious exception: During the 1990s, older categories, for instance, the 26- to 34-year-old age group, had higher rates of lifetime drug use than slightly younger ones, such as the 18- to 25-year-old age group, simply because their *lifetime* rates reflected use when they were younger. But their *current* rates of use—use in the last year and month—remained significantly lower.) Drug use is an expression of lifestyle, and lifestyle is a reflection of age-related life-cycle patterns—and these life-cycle rates are not likely to change on a whim.

As we can see from Table 1-2, in 2011, only 3.3 percent of 12- and 13-year-olds had used at least one illicit drug—any illicit drug—during the previous month. This percentage rose fairly rapidly into the early, middle, and late teen years, reached a peak in the 18- to 20-year-old bracket (24%), and, with a couple of tiny wrinkles, declined year by year and decade by decade after that. About one in 7 or 8 people between the late twenties and early thirties (13%) and 8.5 percent age 35 and older used one or more illegal drugs during the month prior to the survey. Illegal drug use is *strongly* related to one's age or position in the life cycle. Drug use begins at a low point, rises in early adulthood, and declines fairly steeply after that. After the age of 35, drug use falls to a point less than half of what it was during the peak years, and after the age of 65, to less than to one-twentieth.

TABLE 1-2 Illicit Drug and Alcohol Consumption by Age, 2011

Use in Past Month							
Any Illicit Drug		Any Illicit Drug Other than Marijuana		Alcohol		Binge Alcohol Consumption	
Year	Month	Year	Month	Year	Month	Year	Month
12–13	7.1	3.3	5.5	2.3	7.7	2.5	1.1
14–15	18.7	9.2	10.5	4.1	26.3	11.3	5.7
16–17	30.2	17.2	14.4	5.8	47.8	25.3	15.0
18–20	38.7	23.8	18.3	7.4	66.5	46.8	31.2
21–25	32.9	19.9	16.8	6.7	83.9	69.7	45.4
26–34	21.4	12.9	11.0	4.8	79.2	63.8	35.7
35+	8.5	4.9	4.0	1.8	66.8	53.1	18.7

Source: Results from the *2011 National Survey on Drug Use and Health: National Findings, Detailed Tables,* SAMHSA, 2012.