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ROSS COOMBER, KAREN McELRATH,
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preface

When Sage Publications initially approached us to undertake this project there was a mixture of excitement and trepidation mixed with a healthy dose of scepticism. On the one hand, we firmly agreed with the idea itself and believed the 'drug field' to be in need of a text that effectively bridges the gaps between the kinds of texts commonly available to those new to engaging with substance-related issues, but on the other were unsure as to how successful this might be in practice. Commonly, standard textbooks dealing with drugs that are not simply introductory texts will focus in on a specific area (for example, crime; treatment; drug policy) and deal with that in some detail. Alternatively, most introductory texts that cover a greater breadth of material and issues often struggle to provide a sufficiently critical stance on the topics dealt with and provide little more than a basic overview of the areas and also seek to cover almost everything about drug-related issues they can. In some examples this results in huge, very expensive encyclopedias too big to easily 'dip' into and too costly for anything but the most well-endowed libraries. The challenge we accepted then was to provide insight into around 50 areas of interest that relate to substance use in society that we considered to be of the greatest relevance for informing an open-minded audience about the use of drugs in society. Not everything that could have been in the book is in it and the book could easily have been twice as big either in terms of having an extra 50, or more, concepts or by spending twice the length of time on each concept we have included, or both. In the end we have worked within the parameters set by the publisher with one agreeable eye on the laudable aim set by those parameters: to provide accessible, critical insight into important key concepts related to drug use in society that is affordable and portable. The other key difference between this text and nearly all others on the market dealing with drug-related issues is the way that many of the issues are contextualised by reference to a genuinely international perspective. Insight is provided that locates many concepts outside of a simple European or North American context and provides reference where possible to broader relevant geographical examples. In this sense the concepts are all approached with an attempt to provide the reader with a sense of drug use around the world and beyond their own shores. What this does quite clearly in numerous concepts is to provide the reader with an awareness of how, for example, patterns of drug use or risk-taking behaviour, cultures of drug use, approaches to treatment and/or drug control and how drug problems are understood differ from what they may have previously assumed or experienced in their own locality as universal views or practice.

Specific examples of how the concepts and issues are located differently across borders can be seen when looking at, in Section I of the text which has a focus on Types of Drugs and Patterns of Use, **prevalence and trends in illicit drug use** generally but also specifically **addiction; legal drugs; binge drinking, and raves and circuit parties; dance drugs/club drugs** and most especially in **cross-cultural and traditional**

drug use. An international perspective is also valuable in Section II, which considers specific issues relating to drug effects. In this section it is valuable to appreciate the differences around the world in relation to **drug effects: drug, set and setting**; **medical marijuana and other therapeutic uses of illicit drugs**; **novel psychoactive substances**; **drug-related violence**; **HIV/AIDS and other blood-borne viruses**, as well as the conceptual differences that can be found in relation to concepts such as **the gateway hypothesis/stepping stone theory**. In Section III where there is a focus on drug policy, treatment and perceptions of the drug problem we find that an international or comparative perspective is particularly valuable when considering **drug treatment and quasi-compulsory treatment (QCT)**; **the new recovery approach**; **international drug control history/prohibition**; **drug markets – difference and diversity**; **drug trafficking**; **crop eradication, crop substitution and legal cultivation**; the **war on drugs**; **drug testing in schools and workplaces**; **drug courts**; **decriminalisation, legalisation and legal regulation**; **liberalisation**.

The 'issue' of drug use in society is not a simple one. Much that is commonly thought about drugs is misconceived and much so-called commonsense understanding is unproven or simply false. Because of this a further aim of the book was to provide – wherever possible – readers with an opportunity to gain fruitful knowledge about drug use related issues that would stretch their current understanding and beliefs and expose them to ideas and concepts that encourage them to push the boundaries of how they conceptualise drugs, drug use and drug-related problems. There are numerous examples in the text where normative judgements and beliefs around these issues are confronted. Not all drugs do the things to people they are commonly thought to do (see, for example, **drug effects: drug, set and setting**; **addiction**; **drug-related violence**; **medical marijuana and other therapeutic uses of illicit drugs**) nor do drugs always represent a threat to individuals, communities and society (see **cross-cultural and traditional drug use**) or perhaps in quite the ways suggested (see **drug scares and moral panics; new psychoactive substances/'legal highs'**). How drug use should be understood and approached and dealt with is also highly contested and Sections II and III of the book deal with many of the issues in some depth and variety.

By way of how to read the book: it can be both 'dipped' into for insight into specific topic areas or it can be read as whole. In terms of the latter, the reader would gain cumulative knowledge about drug use and supply and the impacts of drug use on individuals and society as well as how society has viewed and responded to drug use historically and in the present day and some of the options it has beyond a simple approach mostly encapsulated by criminalisation and prohibition.

Ross Coomber, Karen McElrath, Fiona Measham and Karenza Moore

Section I

Types of Drugs and Patterns of Use

1 What Is a Drug/Medicine?

A drug is any psychoactive substance that can alter the way the mind or body works, regardless of legal status or medical approval. It can be synthetic or produced from natural sources and can be used for a variety of reasons including medicinal, recreational and spiritual.

The perceived benefits of natural botanical substances have led almost all societies throughout history to extract the desired active ingredients from plants, minerals and fungi for their perceived curative, preventative, therapeutic or spiritual properties. Along with these drugs extracted from the natural world, drugs can also be synthesised in laboratories and produced within the human body. The effects of psychoactive substances vary greatly and can alter the way a person thinks, feels or behaves, along with changes in a person's perception of themselves and the world around them.

There are two main ways to define drugs. First, a distinction may be drawn between medicines, which are medically sanctioned psychoactive substances used for clinical purposes, and drugs, which are controlled substances whose use is not sanctioned either by law or by medical practitioners. Second, drugs can be classified according to their pharmacological make up and attributed psychoactive effects. However, the definition of what is a drug, and the distinctions between drugs, substances and medicines are disputed.

MEDICO-LEGAL DEFINITIONS OF DRUGS

First, in terms of the medico-legal definition, drugs can refer to psychoactive substances with a range of different legal statuses, including legal, illegal and quasi-legal drugs:

1 *Legal* drugs are those that can be legally sold, possessed and used, albeit often with certain restrictions. They include tobacco, alcohol, caffeine, volatile substances, and over-the-counter and prescription medicines.
2 *Illegal* or *controlled* drugs are those whose sale, possession or use constitutes an offence under the Misuse of Drugs Act 1971 in the UK, the Comprehensive Drug Abuse Prevention and Control Act 1970 in the USA and equivalent legislation in other countries. In the UK, illegal use of controlled drugs is defined as the 'non-medical usage of the drugs controlled under the Misuse of Drugs Act'. Furthermore, legal sanction of specific drugs can also relate to their

physical state, so that in the UK prior to 2005 possession of psychedelic or 'magic' mushrooms containing psilocin in their fresh state was legal, but if prepared for consumption in any way (such as dried or boiled), possession was illegal and the drug was classified in the most harmful category (Class A) under the Misuse of Drugs Act 1971, prior to the Drugs Act 2005 which extended control to psilocin in all forms.

3 *Illicit* or *quasi-legal* drugs is a less clearly defined term, which includes the 'grey area' between legal and illegal drugs such as those drugs that are not legally controlled but may face certain formal or informal restrictions on their preparation, sale or use. Three British examples are given here. First, in terms of *preparation*, in the UK before the Drugs Act 2005 brought all forms of psilocin under control, it was the preparation of psilocin or 'magic mushrooms' for consumption that made it illegal but it was not controlled in its freshly picked form. Second, the *sale* of solvents is restricted to over 16s and tobacco to over 18s in the UK. Third, its is illegal to possess GBL (gamma-butyrolactone) if intended for human consumption but not for *use* as an industrial cleaner. Certain drugs may be available on prescription but can also be purchased illicitly and without a prescription (for example, on the Internet), but are not socially sanctioned if used other than for their intended purpose, such as the 'misuse' of prescription medicines for 'recreational' purposes for example, the erectile dysfunction medication Viagra (sildenafil) (see 8 **typologies of drug use**). Most recently, some novel psychoactive substances (see **novel 18 psychoactive substances**) could be considered illicit in that they are not formally controlled by legislation, at least when they first appear, but their use is not legally or socially sanctioned and therefore it would be unacceptable to ingest 'legal highs' in many social situations.

Some countries have formalised this quasi-legal status. In New Zealand, for example, an amendment in 2005 to the Misuse of Drugs Act 1975 added Class D to the three pre-existing classifications (A-C), creating a category of drugs for which there were regulations surrounding minimum purchase age, manufacture, sale, supply and advertising. Benzylpiperazine (BZP or 'party pills') was the first drug to be (briefly) placed in this new category although subsequently banned.

In the UK, the Medicines Act 1968 covers the *medical* use of drugs, (prescription, pharmacy and general sales), whereas the Misuse of Drugs Act 1971 covers the *non-medical* use of drugs, criminalising the possession and trafficking (supply, intent to supply, import/export, production) of controlled drugs. These drugs are classified into classes A-C in accordance with perceived levels of harm, and schedules 1–5 in accordance with ease of access. Other jurisdictions have similar classification systems. Recently these classifications have been subject to dispute (Nutt et al., 2010), raising concerns about the relative arbitrariness of such supposedly 'objective' measures of harm which form the basis for legal classification of 'drugs'.

PHYSICAL/PSYCHOACTIVE DEFINITIONS OF DRUGS

Second, in terms of defining drugs by their attributed physical or psychoactive effects, there are four broad pharmacological categories of drugs:

1 *Stimulants* ('uppers') are drugs that speed up the central nervous system, make the user feel more alert and energetic, causing people to stay awake for long periods of time, decrease appetite and make the user feel euphoric. For example, cocaine, amphetamines, nicotine, caffeine.
2 *Depressants* ('downers') are drugs that slow down the functions of the central nervous system and make the user less aware of the events around them. For example, alcohol, opiates (painkillers, for example, opium, morphine, heroin, codeine, methadone, Demerol, Percodan), sedatives/hypnotics (for example, barbiturates, such as Seconal, sleeping medications, tranquilisers such as Valium, Librium and diazepam).
3 *Hallucinogens* (psychedelics) are drugs that distort the senses and one's awareness or perception of people and events, possibly resulting in hallucinations (seeing or hearing things that do not exist). For example, LSD, PCP (angel dust), mescaline (buttons), psilocin (contained in 'magic' mushrooms).
4 *Deliriants* is a fourth category, sometimes submerged into depressants, which includes drugs that result in a dissociative effect between the mind and body, or 'out-of-body' experience. This has led some drugs in this category to be used as anaesthetics with humans and animals, for example, with children and on the battlefield, when traditional general anaesthetics may be considered to be either impractical or too risky for the patient. For example, solvents, ketamine.

It should be noted, however, that the above categories based on psychoactive effect can be modified by overlapping effects as some drugs fall into more than one category depending on the dosage, the individual user and other variables. So for example, cannabis, ketamine and alcohol are all perceived to have some stimulant properties at lower doses, but become predominantly sedative at higher doses. Furthermore, although the specific drug and strength of dosage is important, the existence and amount of other additives or adulterants, simultaneous use (see **6 polydrug use)**, the physical and psychological characteristics of the individual user and the wider environment can also influence the psychoactive effects that a drug can have upon the user.

Other typologies of drugs include a distinction favoured in mainland European and Nordic countries between 'hard' drugs and 'soft' drugs (see **8 typologies of drug use**). 'Hard' drugs usually include those drugs which are seen as more likely to result in 'addiction' (see **4 addiction**), daily or problem use of drugs such as heroin and crack cocaine. A 'soft' drug primarily relates to cannabis but may also include other drugs such as those which are used occasionally and/or 'recreationally' and may also include hallucinogens and MDMA. In the Netherlands the distinction between 'hard' and 'soft' drugs is integral to their drug policy, with an

official tolerance of the sale and use of small amounts of cannabis by Dutch residents in designated 'cannabis cafes' or coffee shops in order that cannabis users may access their drugs without making contact with networks of 'hard' drug suppliers (see **19 the gateway hypothesis**).

Drugs are not necessarily external substances. Within the body too, naturally occurring substances alter the way the mind and body works. Dopamine, serotonin and creatine, for example, are all naturally occurring substances that alter mood and performance, regulated by the body as well as potentially stimulated by psychoactive drugs. Given sugar and chocolate's effects on the body, they too have been described as drugs, although this expansion of the term to include such substances has been contested leading to a questioning of the term itself.

CRITIQUES OF THE TERM 'DRUG'

The debate between 'drug' and 'medicine'

The term 'drug' is both socially contested and culturally context-specific. Some countries (for example, the UK) distinguish between substances that are medically and legally sanctioned known as 'medicines', and substances that are disapproved of in some way and known as 'drugs'. By contrast countries such as the USA term all psychoactive substances regardless of legal status or medical sanction as 'drugs', as epitomised in the term 'drug store' rather than pharmacy. Other countries do not have a word for 'drugs' and do not make a distinction between socially sanctioned 'medicines' and socially disapproved or illicit 'drugs'.

For many researchers and commentators, particularly in Western societies, the distinction between a drug and a medicine is the difference in its formal or informal acceptability. As Mary Douglas (1978) expressed it, 'a drug is a chemical which is in the wrong place at the wrong time'. It has been argued that the distinction between 'drugs' and 'medicines' relates less to their relative physical or social harm and more to issues of regulation and social control (Ruggiero, 1999; Blackman, 2004). As Derrida famously noted, 'there are no drugs in "nature" … the concept of drugs is not a scientific concept, but is rather instituted on the basis of moral or political evaluations' (1993, in Fraser and Moore, 2011: 10). Thus the concept of drugs, like the concept of addiction, can be considered to be socially constructed and based on historical and cultural context, value judgements and norms.

A distinction is sometimes drawn between legitimate drug 'use' and drug 'misuse' where the drug taking is judged to be inappropriate, dangerous and addictive (see **8 typologies of drug use**). Indeed Fraser and Moore have suggested that 'the category of drugs is an entirely political one … it contains all substances society disapproves of at a given time, and which society says normal people should avoid, and want to avoid … the terms "addiction" and "drugs" need therefore to be seen as social, cultural and political categories' (2011: 11). Additionally, MacGregor has noted that some cultures do not have a word to describe the concept of addiction.

The debate between 'drug' and 'substance'

There is also a debate between the terms 'drug' and 'substance'. The 1992 World Health Organisation expert committee included both legal and illegal psychoactive substances within its definition of the word drug – including alcohol and tobacco. By contrast the 1997 World Drug Report made a distinction between substances (which includes alcohol and tobacco) and 'the unauthorised or non-medical use of drugs which, because of their potential for causing dependence, have been brought under international control' (UNDCP, 1997: 10).

Given the contested nature of the term 'drug', some researchers have argued for the use of a more neutral term such as 'substance use' rather than 'drug use'. In making the case, Ettorre defines substance use as:

> Any substance, chemical or otherwise, that alters mood, perception or consciousness and/or is seen to be misused to the apparent detriment of society and the individual. By replacing 'drug use' with 'substance use' we are explicitly including new discourses on bodily management and regulation … from the viewpoint of women, 'substance use' is a more illuminating notion. (1992: 7)

SUMMARY

A 'drug' is usually understood as a psychoactive substance which alters the way that the mind or body works, and can be extracted from nature, synthesised in laboratories or produced within the human body. However, what counts as a 'drug' varies between historical and cultural contexts and the term can be seen as politically and morally value-laden in terms of which substances are legally and medically sanctioned or socially disapproved of, rather than related to the intrinsic qualities of the substance itself and its effects on the user.

REFERENCES

Blackman, S. (2004) *Chilling Out: The Cultural Politics of Substance Consumption, Youth and Drug Policy*. Maidenhead: Open University Press.

Douglas, M. (1978) *Purity and Danger: An Analysis of Concepts of Pollution and Taboo.* London: Routledge and Kegan Paul.

Ettorre, E. (1992) *Women and Substance Use*. Basingstoke: Macmillan.

Fraser, S. and Moore, D. (2011) *The Drug Effect: Health, Crime and Society.* Melbourne: Cambridge University Press.

Nutt, D., King, L. and Phillips, L. (2010) 'Drug harms in the UK: a multicriteria decision analysis', *The Lancet*, 376 (9752): 1558–65.

Ruggiero, V. (1999) 'Drugs as a password and the law as a drug: discussing the legalisation of illicit substances', in N. South (ed.), *Drugs: Cultures, Controls and Everyday Life*. London: Sage.

United Nations Office on Drugs and Crime (1997) *World Drug Report*. Vienna: UNODC.

2
Prevalence and Trends in Illicit Drug Use

In behavioural or medical terms prevalence *refers to the extent to which something, like a disease or in this case drug use, occurs within a given population. For the purpose of this chapter the populations under consideration will be both worldwide and national with a focus on illicit substances.* Trends *are patterns that take place over time. When we look at drug use prevalence and trends we can see how much drug use is taking place, what changes in drug use have occurred and are occurring, where these changes are occurring and in relation to which substances.*

HISTORICAL CONTEXT

Drug use for recreational pleasure involving products from a multitude of naturally occurring substances (for example, plants, reptile venom/secretion, fungus, among others) has been a feature of nearly all societies for thousands of years. Depending on the particular moment in history and the particular group, we can see that drug use has been both extensive, and 'everyday' (like the current use of tea and coffee) in its usage, or that it has been highly ritualised, restricted and used for specific reasons such as religious ceremonies or something in between. Different drugs can be seen to have had different uses and meaning to different groups and for these to have shifted over time. In other words, a drug or substance does not carry with it a pre-determined or inherent way of being used, of being understood or a quality that means that society will react to it, or use it, in a particular way.

In terms of prevalence and trends we have no explicit data for the pre-modern and traditional worlds but we do know that specific forms of drug use used to correspond with the local availability of the substances. So Amazonian tribes would use hallucinogens available from vines and plant growth local to them and Asian communities found that local poppy and hemp plants provided opium and cannabis respectively. Patterns of use were influenced by culture and acceptability but sometimes also need. In England in the 17th century for example, beer (from local wheat or barley) was consumed as a main part of the diet for most ordinary people from breakfast through to evening (Schivelbusch, 1993).

In the end, exploration, trade, war and curiosity meant that many substances were increasingly exposed to other places throughout the world. Science has of course also added to the list through the production of numerous new drugs and in our increasingly globalised age both drugs and the cultures of use that surround them are more easily transported around the globe than ever before.

Much traditional drug use was highly integrated into everyday life as well as specialised activities of the societies in question and (see also **12 cross-cultural and traditional drug use**), contrary to contemporary views, often was not seen in terms of being a 'problem'.

MODERN CONTEXT

Drug use in modern societies is viewed (by most dominant voices, such as governments, the police and the media) quite differently. The non-medical use of substances that do not have a traditional place in those societies is now seen as essentially problematic and is often prohibited in law. The monitoring of prevalence and trends is seen as an important part of the effort to control such use, use that is deemed as fundamentally damaging to society.

PROBLEMS WITH MEASURING PREVALENCE AND OTHER TRENDS

Measuring prevalence and drug trends is an inexact science. Drug use and other 'deviant' behaviours are hidden and those involved may be less likely to declare involvement in surveys of the kind used to collect prevalence data. Moreover, although some of the prevalence data gives an indication of trends, for example, the proportions reporting having used in the last month, they tend to not to be able to disaggregate those that used once, twice or 20 times. Similarly 'lifetime use' prevalence statistics provide information on all those that have 'ever tried' a drug but this will include those that have used many times a day for decades as well as those for whom that first experience was the cause of them *not* continuing. Simply using prevalence data – as many governments do – as a straight-forward indicator of the nature of the drug problem is thus unhelpful. Prevalence data should be treated with due caution. That said, and with due caution noted, what follows now is an indicative outline of some drug use trends.

THE REALLY BIG PICTURE

In terms of prevalence and drug use patterns, the really big picture is that the last 50 to 100 years has seen an enormous growth in drug use around the world, both in terms of types of drugs being used and the populations that use them. The modern context is one in which there have never been so many drugs taken by so many people for so many different objectives. Within this shift, however, there have been some definite patterns that have emerged around specific types of drugs and drug using behaviour.

WORLDWIDE: PREVALENCE

According to the 2008 World Drug Report (UNODC, 2008a) the previous 10 years saw a relative stabilisation of drug use at around 5 per cent of the world's 15–64-year-old population. This means that around 208 million people around the

world between the ages of 15 and 64 have used an illicit drug at least once in the previous 12 months and that that this has been more or less the case for the recent past. One drug that dominates nearly all the prevalence statistics is that of cannabis. With nearly 4 per cent of the global 15–64-year-old population (or 165.5 million people) using cannabis it literally dwarfs all other forms of drug use by comparison. The next closest – ATS, the amphetamine type stimulants – a group that combines the various amphetamines and various other 'dance drugs' such as ecstasy or ketamine accounts for less than 1 per cent (0.6 per cent) of the global 15–64-year-old population or 24.7 million. Cannabis use is thus nearly seven times more prevalent globally than the use of ATS, 14 times more prevalent than the use of heroin (0.3 per cent or 12 million) and 10 times more so than cocaine (0.4 per cent or 16 million). These figures compare to tobacco use of around 25 per cent of the global population (approximately 825 million) and relative mortality figures, where deaths from all illicit drugs is estimated at around 200,000 a year compared to 5 million a year from tobacco.

REGIONAL PREVALENCE AND TRENDS

ATS (amphetamine type substances)

A regional picture provides a little more detail. A recent United Nations report on ATS trends (UNODC, 2008b), for example, helpfully points out that ATS use, relatively stable and even in moderate decline in some 'mature' drug market nations in the 'West' and other developed nations, continues to be offset by growths in consumption in the developing world. Europe and North America for example, both regions that are close to the global average of ATS use, show little change in ATS and ecstasy use while ATS use in Africa and the Near and Middle East doubled between 2002 and 2006 (from a threshold lower than the global average). Nearly 55 per cent of the world's amphetamine users (around 14 million) are estimated to be in Asia and most of these to be methamphetamine users in East and South-East Asia. However, while ATS use overall has more or less stabilised, ecstasy use itself has grown in most parts of the world since 2002.

Ecstasy (MDMA) and ecstasy-group substances

Oceania (a region including Australia, Indonesia and New Zealand and numerous smaller nations), Europe and the Americas have consumption rates for ecstasy-group substances significantly above the global average and remain the primary consumption areas but the highest levels of growth were experienced in East and South-East Asia where they tripled between 2002 and 2006. Most growth of ecstasy use in the developed nations took place prior to 2001 and, at present at least appears to have plateaued, albeit at a comparatively high level. Prevalence of ecstasy-group substances nationally however, compared to cannabis is small. Regionally, ATS/ecstasy usage rates are below 1 per cent of the 15–64-year-old population and are often less than 0.5 per cent.