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## FRAMEWORKS FOR UNDERSTANDING DRUG USE AND SOCIETAL RESPONSES

Robin Room and Wayne Hall

### **Brief overview**

1. The social response to problematic alcohol and other drug use depends on how alcohol or other drug use is defined and the prevailing ‘governing image’ of use - a sin, a crime, a disease, or a disability.
2. Depending on how the problem is defined, different professions and institutions will have the main responsibility for the social handling of the problems – religious institutions for sins, the police and courts for crimes, doctors and hospitals for diseases, and welfare institutions for disabilities.
3. Definitions of alcohol, tobacco and drug problems have shifted over time in Australia and elsewhere. A century ago, doctors considered drugs and alcohol in the same framework. But then there was a major split between ways of thinking about alcohol and drugs for most of the 20<sup>th</sup> century. Since the mid-1980s, the ways of thinking have been coming together again.
4. Whether alcohol and other drugs should be thought of primarily in terms of crime or in terms of disease is still strongly contested.

5. In Australia, as elsewhere, there has been a substantial growth of treatment and assistance agencies in the health and welfare sectors, but a larger portion of government resources still goes to criminal justice responses.
6. This chapter challenges us to consider five new ideas and trends which have the potential to disrupt the current frame of reference, governing image and policy responses to alcohol, tobacco and drug problems.

### **Key terms and concepts**

- Governing images of alcohol and other drugs
- Social responses matched to governing images
- Global burden of disease
- Prohibition
- Free-market ideology

### **Introduction**

This chapter deals with how we think about the use of alcohol, tobacco and drugs, the problems related to their use, and how we should respond to these problems. Our subject is what some have called “governing images” of drug use (Room, 2001). We argue that there are a limited number of ways in which we think about drug use and problems. This is despite the variety of **psychoactive substances** that have been used by humans, the many different problems that their use may cause, and the many possible ways in which we can respond to these problems. We also argue that these governing images are connected to a small number of major professions and institutions that handle these problems in modern societies. We will

show that these conceptions, professions and institutions have spread across cultural boundaries and become very widespread in their influence on today's world.

We start by showing how ancient some ways of thinking about drugs are and then discuss governing images that have only become established more recently. We note: that the dominant governing images have changed back and forth over time; that these images have often differed for different drugs; and that these images are not mutually exclusive, so hybrids can and do emerge.

The dominant governing image typically suggests how substance use problems should be handled by specifying what particular institutions have control over them and which professions have custody of the issue. One trend that has been almost universal over the last 60 years has been the emergence of a specialised societal system that responds to alcohol and other drug problems (although not usually tobacco). Separate "alcohol and other drug" (AOD) treatment systems have become a fairly stable feature in many developed societies. Societies differ, however, in which of the more general systems used for handling social problems (e.g. social welfare, criminal justice, or health care) have overall control of the AOD system (Klingemann, Takala & Hunt, 1992; Klingemann & Hunt, 1998).

We then consider five new ideas and trends which have the potential to disrupt these long-standing governing images, and we briefly consider their implications. We argue that there is substantial instability built into the systems of thinking and acting on substance use problems. This is driven, in part, by the intractability of these problems and by the limited successes that each of the major governing images has had in dealing with them. As Kettil Bruun (1971) remarked about the Finnish history of switching between different models for

handling alcohol issues, “the consistent frustrations concerning the relative lack of success in fighting alcoholism made us move compulsively from one model to another”.

#### Dealing with problematic use: three frames

As discussed in the chapter (xxx) on the history of drug use, the use of psychoactive substances is threaded through recorded human history in nearly all societies. In the earliest times, such substances were often used as medicines (Bruun, 1986), but they could also be a source of pleasure and solace for individuals, and serve communal functions such as religious observance and fostering sociability. These substances were often valued goods whose scarcity and social rules often limited their use to individuals in designated roles (e.g. religious figures) or the socially powerful (rulers and their associates).

Alcoholic beverages were among the earliest used **psychoactive substances** in most cultures, and attitudes towards alcohol have influenced attitudes towards later psychoactive substances in these cultures. As recorded in the Bible and other ancient documents, it was well recognised that alcohol could bring troubles along with its pleasurable effects. Psalm 104, for example, speaks of “wine to gladden the heart of man”, but Proverbs warns that “wine is a mocker and beer a brawler” (Proverbs 20:1). The Christian apostle Paul counselled his followers to “use a little wine for the sake of your stomach” (1 Timothy 5:23), but on another occasion he exhorted them to “be not drunk with wine, wherein is excess” (Ephesians 5:18).

The Jewish and early Christian approach to alcohol was to counsel moderation, rather than **abstinence** (i.e. no alcohol at all). Islam chose to forbid use of alcohol, and many Islamic societies have enforced this rule by prohibiting the production, sale and use of

alcohol (Michalak & Trocki, 2006). From earliest times, then, leading religious traditions differed in whether they allowed alcohol use while forbidding intoxication, or they treated any alcohol consumption as a sin. Often the proscription was carried into law, so that intoxication, and sometimes any use of alcohol, were defined as crimes. So the choice between a moral or legal injunction not to use a drug and rules that allow its use while proscribing intoxication has ancient roots. These comprise two very general societal orientations (moderation vs. abstinence) that are often adopted towards psychoactive substances.

A third orientation only became part of common thinking in the early 1800s: the idea that repeated intoxication can become a disease. The idea was first developed for alcohol (Levine, 1978) but by the 1880s it had been extended to other substances, such as the opiates and sedatives, such as chloral hydrate (Room, Hellman & Stenius, 2015). By the late 1880s, the existence of competing frameworks for interpreting substance use was consciously recognised. As Norman Kerr, a leading addiction physician of the time, put it: “In drunkenness of all degrees of every variety, the Church sees only the sin; the World the vice; the State the crime. On the other hand the medical profession uncovers a state of disease” (Kerr, 1888).

While the frames of sin or crime can be applied either to any use or only to intoxication or heavy use, the framing of substance use as a disease (usually with a label such as **addiction** or **dependence**), is only applied to heavy and repeated use. At the heart of the addiction framing is an important idea of the double loss of control – loss of control over one’s substance use, and over one’s life as result of the substance use. This is expressed in the

First Step of Alcoholics Anonymous: “We admitted that we were powerless over alcohol – that our lives had become unmanageable” [[www.aa.org.au/members/twelve-steps.php](http://www.aa.org.au/members/twelve-steps.php)].

The disease concept has built into it a distinction between drug use per se and the diseased condition, which may be distinguished from immoderate use in various ways. In the disease framing, a lesser frequency or intensity of drug use is not seen as a symptom of a diseased condition. However, the belief that abstinence should be the only goal for someone who had become addicted was already commonplace among 19th century doctors.

At the social policy level, the idea of addiction as the usual outcome (or at least a very likely outcome) of alcohol or drug use became a powerful argument against initiating the use of alcohol or drugs. “It’s so good, don’t even try it once” was the advice contained in the title of a book on heroin published in the early 1970s (Smith & Gay, 1972). The idea that addiction was such a horrific outcome of substance use was used to justify heroic preventive countermeasures that were first developed in the late 19th century with respect to alcohol policy, as temperance movements turned from advocating moderation to advocating the prohibition of alcohol. It is an idea that became and remains fundamental to the modern systems that prohibit the use of “controlled substances” for any but narrowly defined medical or scientific purposes.

“Addiction” is mentioned only once in the UN Single Convention on Narcotic Drugs of 1961 - the keystone of the modern international drug prohibition system (see Chapter **xxx**). This is in the Preamble as a key justification for the system: “addiction to narcotic drugs represents a serious evil for the individual and is fraught with social and economic danger to mankind” (Room, 2006a).

### Shifting attitudes towards alcohol, tobacco and other drugs

In the late 19th century, and for some years into the 20th century, alcohol, tobacco and “**illicit drugs**” (as they are now collectively known) were considered in a common frame in most Western societies (e.g. Towns, 1915). The frame first became established for alcohol, under the impetus of the temperance movement. The temperance movement was the second most important social movement (after the labour movement) in that era in the USA, Britain and its dominions, and in much of northern and central Europe.

The production of spirits and beer was industrialised early in the industrial revolution, and the flood of cheap alcoholic beverages had created massive social and health problems in country after country (e.g. Blocker, 1989; Nicholls, 2010; Room, 1988). Responses to these problems eventually took the form of mass movements among workers as well as elites. While the initial emphasis in the movements was on mutual help and persuasion against heavy drinking, by the late 19<sup>th</sup> century the leading edge of the movement was pressing for the prohibition of alcoholic beverages.

Prohibitions were applied after 1910 in a total of 13 autonomous countries, including Russia, the United States and Canada. They were also applied to “native” populations in Australia and a number of other British dominions, and there was an agreement to prohibit spirits in most of Africa (Bruun, Pan & Rexed, 1975; Schrad, 2010). Under the impetus of the temperance movement, cigarettes were also prohibited for varying periods between 1896 and 1927 in 15 US states (Alston et al., 2002).

The temperance movement also energetically campaigned against the opium trade. These efforts led to the first international drug treaty in 1912, which had lasting effects in the form of the present-day system of international drug prohibition treaties (Babor, Caulkins, Edwards, Fischer, Foxcroft, Humphreys, Obot, Rehm, Reuter, Room, Rossow & Strang, 2010, pp. 203-220).

By the early 1930s, a growing reaction against alcohol prohibitions led to the repeal of most of them. This left the Moslem world as the main location of alcohol prohibition policies. In Australia, the push for alcohol prohibition failed, but the temperance movement succeeded in substantially cutting down the availability of alcohol: in Victoria, for instance, half of the pubs were closed by state action in the early 20<sup>th</sup> century (Livingston, 2012), and for some decades alcohol could not be sold after 6pm in most parts of Australia.

The reaction against temperance thinking (against “wowserism” in the Australian vernacular) dominated the political discourse about alcohol, with the exception of drink-driving, until recently (Room, 2010). Meanwhile, the prohibition of opium, cannabis and other drug use has continued to enjoy majority support.

Thus in Australia, as in the USA and elsewhere, thinking about tobacco and alcohol was detached for most of the 20<sup>th</sup> century from thinking about “narcotic drugs”. This was reflected in marked differentiation at the policy level. In Figure 1, the historian David Courtwright (2005), punning on “Mr. Toad” of *The Wind in the Willows*, illustrates from U.S. history the wild swing in the 20<sup>th</sup> century for alcohol and tobacco (A and T) to “the other side of the road” from other drugs (OD).



## INSERT FIGURE 1

In Australia, thinking about psychoactive substances was gradually brought back together at professional and intellectual levels from the late 1970s onward (e.g. Senate Standing Committee on Social Welfare, 1977), although in many aspects of policy and practice they still remain divided.

The starkest difference between the frames for illicit drugs and those for alcohol and tobacco remains the ancient distinction between whether the society allows temperate use or bans all but medical use. Where use is allowed, the main emphasis of social policy is on limiting the harms from use, by a variety of regulatory means. Thus Australian states and territories require that those selling alcoholic beverages be licensed, and impose requirements as a condition of the license (Manton, Room, Giorgi, & Thorn, 2014). The way tobacco is sold is also subject to increasing regulation of the composition of the product, and its packaging, labeling and promotion (Tobacco Working Group, 2009).

The governmental approach to alcohol and tobacco is, in literal terms, harm reduction. While other considerations enter into the policies, from the perspective of public health and order, the government aims to minimise the problems caused by these substances. The approaches include efforts to limit or discourage use, but stop well short of prohibiting use.

With respect to illicit drugs, there is no acceptance of nonmedical use. The main policy goal is to deter all use, primarily through “**supply reduction**” aimed at the illicit market and “**demand reduction**” aimed at preventing or stopping use. In Australia from the mid-1980s onward, the approach has also included a more restricted form of “**harm**

**reduction”** (Riley, Sawka, Conley, Hewitt, Mitic, Poulin, Room, Single & Topp, 1999).

These policies have aimed to limit the harm experienced by those who are using drugs heavily or dangerously in spite of their illegality (e.g. heroin injectors). This approach which accepts the reality of some illicit drug use has been controversial internationally, but it is now an accepted aspect of Australian drug policy.

#### Governing images and **action models**: within frameworks, and across them

The three main frames of understanding problems with substance use - sin, crime and disease - are still very much with us. Associated with each frame are major social institutions and their associated professions. Sin usually goes with churches and other religious institutions, and is dealt with by clergy and pastoral staff. Crime is generally seen as the province of the criminal justice and court system and as something to be dealt with by the police, judges and probation workers. Disease is usually dealt with in the health care system by doctors, nurses and hospital staff. A mental illness frame can be identified as a subsystem within the disease frame. In modern welfare states, we can also distinguish a fifth frame for societal responses: the welfare and associated social systems staffed by social workers and other welfare workers (Figure 2).

#### INSERT FIGURE 2

Each set of institutions and professions has its own set of “governing images” and ways of dealing with the problems within its professional realm (Bruun, 1971; Room, 2001). In the health system, for instance, the overarching framing is in terms of disease and its absence (“health”).

But there can also be finer differentiations within the frame in terms of how the problem is seen and what this means for professional actions. Is alcoholism a disease like an allergy, bronchitis, syphilis, or diabetes? These are very different disease analogies and they imply different management plans. If there is a “cure” for the condition, the approach is settled, but if there is not, as is the case for substance use problems, there may be competing approaches adopted within the same professional frame (Room, 2001). For example, some health professionals may regard abstinence as the only therapeutic goal to be pursued by engaging patients in 12-step mutual help groups. Other professionals may see a return to controlled use as a reasonable goal of treatment and pursue this using **cognitive behavioural therapies** (see Chapter xxx).

The concepts used to label these frames, and the institutions and professions associated with each of them, are well articulated. But problems of substance use are varied, and not confined neatly within any of the professional and institutional frames. A person with a social or health problem related to drinking or drug use, or to another’s use, may appear at the door of any of the social response systems (Figure 2). At the other end of the schema, there is also no one-to-one relationship between professions and institutions, on the one hand, and the actions taken to respond to the alcohol or drug problem, on the other. There is, indeed, rather little specialisation in action taken, except for physicians’ monopoly on prescribing medicines. A therapeutic intervention other than a prescription could be undertaken within any of the frames.

The different frames are often portrayed as mutually exclusive. The alcoholism movement in 1950s America, for instance, promoted the slogan “alcoholism is a disease”

with the aim of replacing the “old moral approach” (Room, 1983). However, diseases are in fact often heavily moralised (think of syphilis in Ibsen’s *Ghosts* or cancer in Susan Sontag’s (1978) analysis in *Disease as Metaphor*). Hybrids of these models have been a recurrent feature of the way that societies handle alcohol and drug problems. The most common form of these is some combination of legal coercion and clinical counseling (Christie, 1965), as implemented in the USA and elsewhere since the 1990s in the “**therapeutic jurisprudence**” of “**drug courts**” (Klag, O’Callaghan & Creed, 2005).

### The rise of specialist AOD treatment systems

As noted above, problems arising from substance use are of many different kinds, and may require a response from some or all of the major social institutions and professions. For a drug overdose or alcohol-related injury, it makes the most sense to call in the health system; for child neglect or homelessness arising from parental substance use, the welfare or, in some societies, the religious systems; and for drunken brawling or drugged-driving, the police and court system.

Alcohol and drug problems have often been seen as marginal to the central work of each of these major institutions and professions (for Australia, see (Room, 1988)). One policy response, in country after country, has been the creation of separate treatment systems for persons with problems arising from the use of alcohol and/or drugs (Klingemann et al., 1992; Klingemann & Hunt, 1998). These systems have often been lodged formally within the health system (although usually with very few doctors involved), sometimes within the welfare system (alcohol but not drugs in Denmark), sometimes in both health and welfare (as in Sweden), and sometimes in the prison system (Malaysia in the 1990s - Tanguay, 2011).

Although alcohol treatment and drug treatment systems were often initially set up separately, in recent years in most societies they have merged into a common system, often termed the “alcohol and other drugs” or AOD sector. Tobacco has usually remained separate and continued to be handled within the health care system, probably because of the lack of conspicuous behavioural and social problems related to cigarette smoking. Despite some efforts to “mainstream” AOD treatment within the general health system (e.g., opiate substitution maintenance provided by general practitioners in Victoria), separate AOD systems have been a stable feature of many developed societies’ response to drug problems in recent decades.

#### The disruptive potential of new ideas and trends

There are a number of trends in thinking about alcohol and drugs that may potentially disrupt the standard frames and policy responses to alcohol and other drug problems.

#### *Contributions to the **Global Burden of Disease**.*

In recent years, the World Health Organization (WHO) and other institutions concerned with global health have attempted to measure the “global burden of disease”(GBD), that is, the major diseases that contribute to premature death (life years lost due to illness) and disability (life years lived with disability). These exercises have also assessed the contributions that modifiable “**risk factors**” make to the burden of disease. Among these risk factors have been alcohol, tobacco and other drugs. Given that the project has been sponsored by WHO , the focus has been on adverse health outcomes. The social

problems (such as criminal activity and failures of social role) arising in populations from alcohol and other drug use have been omitted from these considerations. Nevertheless, psychoactive substances still make a substantial contribution to global ill-health, accounting for almost one-tenth of the total estimated burden of disease in 2000 (Ezzati, Lopez, Rodgers, Vander Hoorn, Murray & Comparative Risk Assessment Collaborating Group, 2002). The substantial contribution made by tobacco (4.1%) was no surprise but that for alcohol (4.0%) was more unexpected. Both figures contrasted with the much smaller contribution of illicit drugs (0.8%). The most recent update of the contribution of risk factors to the GBD broadly confirmed these results (GBD 2013 Risk Factors Collaborators et al., 2015): in the estimates for 2013, tobacco ranked 2<sup>nd</sup>, alcohol 6<sup>th</sup> and illicit drugs 22<sup>nd</sup> globally among the risk factors.

The results of the burden of disease studies have raised the priority that WHO has given to alcohol issues. They have also raised questions about the imbalance in the current global resources spent on addressing the harms arising from the use of different substances, including in Australia (see also [Chapter 9xxx](#))

#### *Indices of the harmfulness of different drugs.*

The international drug control treaties (see also [Chapter xxx](#)) ban heroin but allow the sale of alcohol and tobacco. When the stringent current control system was established in 1961 it was assumed that the different levels of control applied to these different psychoactive substances reflected the harms that their use caused. No psychopharmacologist has seriously argued since the 1950s that the relative seriousness of addiction or of the harms caused by different drugs is accurately reflected in the international control system. And none of the recent efforts to estimate the comparative harms of different drugs has supported the

system's rankings (Lachenmeier & Rehm, 2015; Nutt, King, Phillips, & Independent Scientific Committee on Drugs, 2010; Room, 2006).

The increasing interest of economists in the drug policy field is likely to further challenge these ratings. Welfare economists, for example, regard consumer preferences as a good, and are therefore surprised to discover that “abuse potential”(assessed in part by how much users like a drug ) is central to the drug control system's assessment of how harmful each drug is (Caulkins, Reuter & Coulson,, 2011; Room, 2011).

### *Neurobiology.*

The US government has made a large investment of public funds in research on the neurobiological bases of psychoactive substance use and dependence. This has taught us a great deal about the effects that psychoactive drugs have on the functioning of the brain, especially when used chronically (Carter & Hall, 2012; Carter, Hall, & Illes, 2012; World Health Organization, 2004).

Two major findings of this work have the potential to challenge current thinking about drugs. First, this work has shown that, to a substantial extent, the psychoactive substances whose effects humans find pleasurable produce their effects by acting on common “reward” pathways in the forebrain. Second, these are the same neural pathways that are also stimulated by common human activities which have survival and evolutionary value, such as eating and sex.

The view of these findings offered by the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) is that addiction is a chronic relapsing brain disease (Volkow, Koob & McLellan, 2016). The claims made for this model have been contested (Hall, Carter & Forlini, 2015). The underlying findings can also be interpreted as subsuming the use of all drugs, licit and illicit, within forms of human behaviour that are seen as normal and positive (Hall et al., 2015). It is doubtful that the rhetorical description of the action of the illicit drugs as “hijacking the brain” can fully neutralise these findings (O’Connor, 2012).



### *Failure of prohibition on the supply side*

As research has accumulated on the minimal impacts of efforts to prevent the supply of illicit drugs, confidence that this policy will produce enduring success has declined (Babor et al., 2010). A recent article, evaluating the effects of the last 50 years of the system, concluded that “no evidence suggests that illicit drug production or use have lessened” while “the system has had many adverse effects on human health and wellbeing” (Room & Reuter, 2012). It concluded that the time is ripe for experimentation with alternative drug control regimes (see **Chapter 9**)

### *The limits of free-market ideology*

The triumph of **free-market ideology** in many developed countries over the past several decades has generally increased the market availability of products like alcohol which are legal commodities but whose availability had previously been limited. The US Supreme Court’s decisions protecting “commercial free speech” exemplify how far the free availability and promotion of goods can be pushed (Sullivan, 1996). It also raises questions about whether a regulated market for a psychoactive substance is possible in the US. Those US states that have legalised cannabis for recreational use have largely adopted much the same approach they use to regulate alcohol (Room, 2014).

In Australia, the National Competition Policy has treated alcohol as if it were like any other market good by fining several states for failing to fully free up the alcohol market (Alcohol and other Drugs Council of Australia, 2004). At the international level, potentially harmful psychoactive substances need to be exempted from the provisions of World Trade

Organization treaties that aim to promote free trade (Room, Schmidt, Rehm & Makela,, 2008) and efforts of tobacco companies in their fight against the plain packaging requirement in Australia are largely based on free trade arguments.

For tobacco, at least, there are signs that the ideological insistence on a totally free market is being pushed back. A similar trend may be emerging for alcohol, although Australian governments are often not in line with this trend (O'Brien, 2013). Stronger regulatory controls for licit psychoactive substances may make a regulatory alternative to prohibition for “controlled drugs” a more promising and viable option.

#### Looking beyond the frames: is there an optimal response, and what might it be?

Psychoactive substances can provide pleasure and solace to humankind, but are also responsible for many and diverse adverse effects, both on the substance user and on those around him or her. Human societies have long struggled with the question of how to achieve the best balance between the pleasures and harms of substance use. On the supply side, in broad terms prohibition has not been successful, but it is also clear that the free availability of these substances can create substantial problems.

There is much that can be learned from the history of efforts in many societies over the last century to take a middle path that allows legal use within a strong regulatory system. One of the lessons of this history is also that such middle-way solutions are inherently unstable; if they are successful in reducing harm, then the restrictions they entail often come to be seen as unnecessary, and they are gradually wound back as a result of political lobbying by manufacturers, suppliers and users. As progressive liberalisation gradually increases use

and harms, critics begin to advocate for a return to increased regulation and restriction to reduce harm.

The greatest and most consistent investment in developed countries in dealing with problems from substance use has been in treating and assisting those most seriously affected by overuse of substances. In most societies, a specialised treatment service for AOD problems has emerged, although alcohol and drug problems are also dealt with in all the other social handling systems. Efforts at earlier intervention - to assess and find less serious cases in the clients of health, welfare and criminal justice services - have generally struggled to have much impact because of the reluctance of these professions to engage in screening. This approach has been most successful with tobacco, where a population-wide reduction in use is well under way in many developed countries. It is fair to say that we still do not know whether there is an optimal societal approach to reducing rates of substance-related problems, and if so what the configuration of services might look like. Nor do we know how such an approach might be sustained in the face of the activities of competing groups with an interest in increasing consumption.

## **Summary**

The use of alcohol, tobacco and drugs is a source of pleasure for many, but also a prolific cause of social and health problems. Throughout recorded history, human societies have tried to limit their use to avoid or minimise these problems. One major choice for a society is whether any use should be accepted and made legal, or whether all use of the drug (other than as a medicine) should be prohibited. If use is allowed, then efforts will be made to reduce harm, that is, problems related to heavy use. The social response to problematic use depends on how the use is defined. There are a limited number of major choices for the

governing images of use – for instance, whether it is seen as a sin, a crime, a disease, or a disability. The problem definition then influences the ways in which a society responds to drugs. Depending on how the problem is defined, different professions and institutions will have the main responsibility for the social handling of the problems – religious institutions for sins, the police and courts for crimes, doctors and hospitals for diseases, and welfare institutions for disabilities.

Whether drugs and alcohol should be thought of primarily in terms of crime or in terms of disease is still strongly contested. In Australia, as elsewhere, there has been a substantial growth of treatment and assistance agencies in the health and welfare sectors, but a larger portion of government resources still goes to criminal justice responses. New and emerging knowledge, such as advances in neurobiology, evaluation of prohibition regimes, free-market ideologies and understanding of the contributions of different drugs to the global burden of disease have the potential to generate new governing images for alcohol and other drugs which may lead to new societal responses.

Food for thought...

- The main governing images of drugs are as sin, crime, disease and disability. Which governing image sits most comfortably with you?
- Should alcohol and tobacco, as legal drugs, be separated out from illegal drugs in terms of how we think about and respond to them? Or do you think it would be better to consider all drugs together?
- What do you think further developments in our understanding of brain chemistry and neurobiology may have to offer by way of either explanations for drug use, drug harms or treatments for drug problems?

## Further reading

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## Useful websites

- Drug Policy Alliance <http://www.drugpolicy.org/resources-publications>
- United Nations Office of Drugs and Crime <http://www.unodc.org/unodc/en/data-and-analysis/index.html?ref=menuside>
- World Health Organisation [http://www.who.int/substance\\_abuse/en/index.html](http://www.who.int/substance_abuse/en/index.html)
- Australian Drug Foundation <http://www.druginfo.adf.org.au/>

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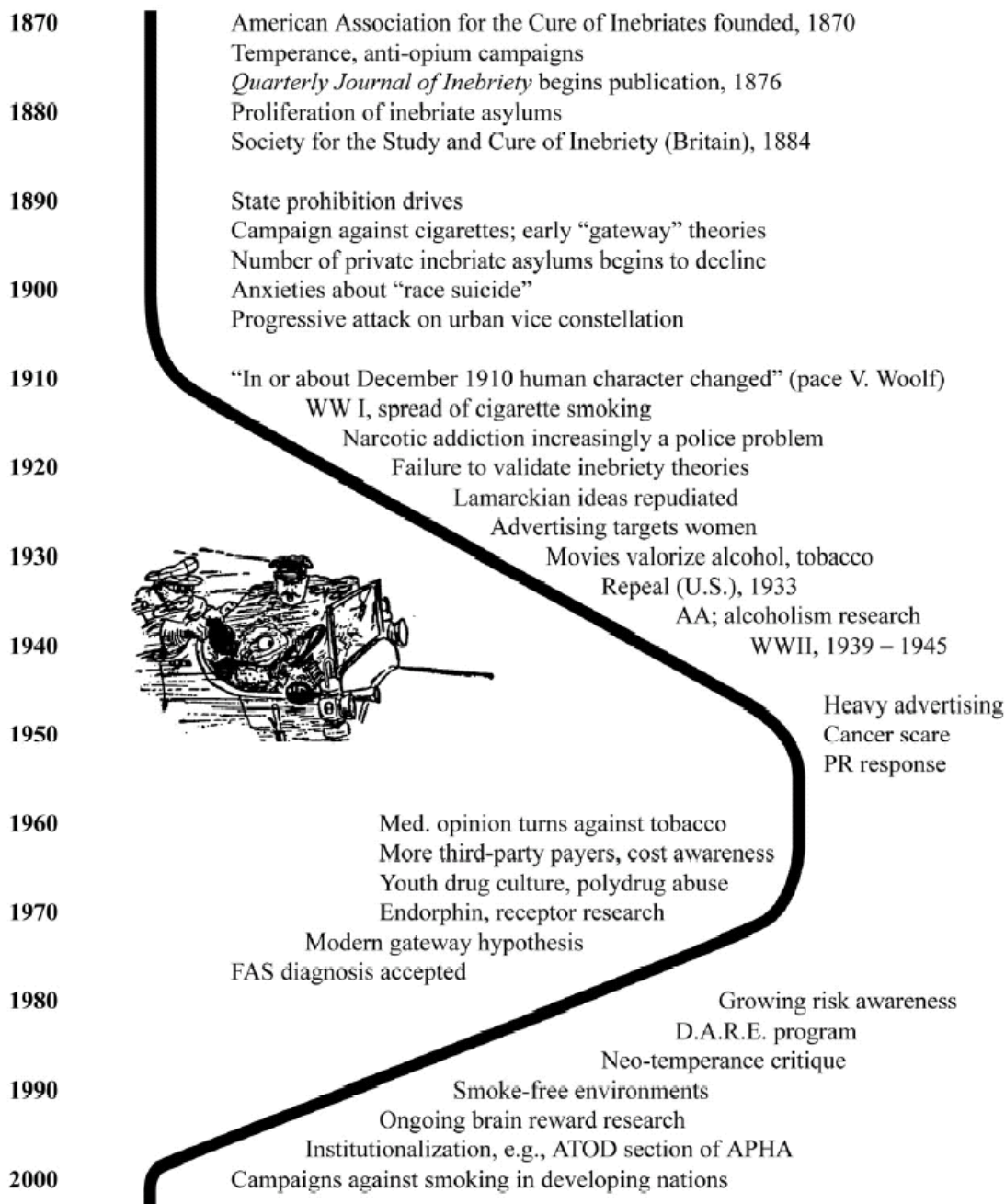
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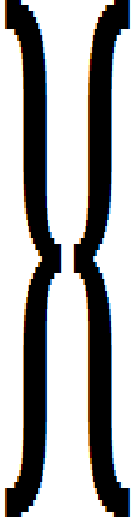
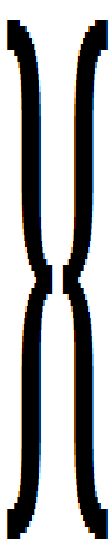
### Emphasis on ATOD Commonalities

### Emphasis on ATOD Differences



Source: Courtwright, 2005

Figure 2. Schema of frames of social handling of substance use problems

Substance.-related problems		Frame	Dominant profession	Institutional base		Action models
Injuries		Physical illness	Doctors	Health institutions		Medicine
Illness						Behaviour. therapy
Loss of control		Mental illness	Psychiatrists	Mental institutions		Psychoanalysis
Violence		Crime	Judges	Criminal justice		Punishment, incapacitation
Sloth		Sin, vice	Priests	Religious institutions		Succour
Intoxication		Disability, destitution	Social workers	Welfare system		Skills training
						Shelter