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Research Paper

Examining social supply among nonmedical prescription stimulant users in the San Francisco Bay Area

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ABSTRACT

In the US, prescription stimulants are prescribed for a variety of conditions including attention deficit hyperactivity disorder (ADHD) and narcolepsy. Over the last two decades, dramatic increases in stimulant prescriptions have led to greater availability and increased risk for diversion and nonmedical use. Our own and other investigators' findings indicate that many drug "suppliers" do not fit into the traditional image of drug "dealers." These suppliers typically do not identify themselves as "dealers," but instead understand their drug distribution as sharing with people they know. Coomber and colleagues' (2007; 2013) concept of "social supply" raises the question: When friends supply or facilitate supply of drugs to friends, is this really dealing? Further, if dealing and supplying are distinct kinds of social transactions, should different types of criminal justice approaches be applied? Social supply extends our understanding of drug dealing as a complex social activity. In this article, we examine the issue of social supply among nonmedical users of prescription stimulants. We conducted a 36-month National Institute on Drug Abuse-funded project to conduct a qualitative, mixed methods study of 150 adult nonmedical prescription stimulant users in the San Francisco Bay Area. We explore intersecting factors, including life stage and social location, that contribute to decisions to use prescription stimulants nonmedically, motivations to use, knowledge about risks and benefits of prescription stimulant use, any adverse health or social consequences experienced, availability, acquisition and diversion of prescription stimulants, and differences in attitudes and behaviours. For this analysis, we rely on participants' narratives concerning prescription stimulant acquisition practices and how they understood these interactions, purchases, and exchanges with the suppliers of prescription stimulants in their social networks. The authors argue that acknowledging the distinction between social supply and "proper" drug dealing would redress the disparity between drug sharing and profiteering particularly regarding criminal sentencing.

Introduction

In the US, prescription stimulants are used to treat a variety of conditions including attention deficit hyperactivity disorder (ADHD) and narcolepsy. Some commonly prescribed stimulants include amphetamines (e.g. Adderall, Dexedrine, Vyvanse) and methylphenidate (e.g. Ritalin, Concerta). According to the 2015 National Survey on Drug Use and Health (NSDUH), during the past year an estimated 17.2 million people aged 12 or older used prescription stimulants. Furthermore, an estimated 5.3 million people aged 12 or older misused prescription stimulants in the past year (Hughes et al., 2016), with 1.7 million current misusers (Center for Behavioral Health Statistics and Quality, 2016). Prescription stimulant "misuse" (what we call "nonmedical") is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told to take a drug; or use in any other way not directed by a doctor. The reported primary reasons for the misuse of stimulants in the 2015 NSDUH were to be alert or to stay awake (26.8%) and to help concentrate (26.5 percent), followed by to help study (22.5%) (Hughes et al., 2016).

The dramatic increases in stimulant prescriptions over the last two decades have led to greater availability and increased risk for diversion and nonmedical use (McCabe, West, Teter, & Boyd, 2014). Misuse and diversion of prescription stimulants is a prevalent and growing phenomenon, particularly among college students (Flory, Payne & Benson, 2014). Hartung et al. (2013) study of stimulant medication use in college undergraduates at four public universities located in the Southeast, Rocky Mountain, and Midwest

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regions of the U.S. found that 81 percent of stimulant misusers without prescriptions got medications from friends, while 45 percent bought them. DeSantis, Anthony, and Cohen (2013) surveyed 2313 undergrads at a large Southeastern university to study illicit college ADHD stimulant distributors. They found that among students with stimulant prescriptions, 52.5 percent had given pills away, while 39.2 percent had sold them. Vrecko (2015) conducted semi-structured interviews with 38 students who used prescription stimulants as a means of improving academic performance on an American university campus.

> The most common way that informants reported obtaining Adderall for non-medical use involved receiving pills from someone known personally to them, well enough to be described as a friend. More than three-quarters of individuals reported such transactions, in which a recipient would typically be given a small supply of pills without expectation of a monetary payment or other financial exchange (299).

Coomber and Turnbull (2007),Coomber and Moyle (2013) and Coomber, Moyle, and South (2016) concept of *social supply* addresses this phenomenon and raises the question: When friends supply or facilitate supplies of drugs to their friends, is this really dealing? Further, if dealing and supplying are distinct kinds of social transactions, should diverse types of criminal justice approaches be applied? Social supply extends our understanding of drug dealing as a complex social activity. Our own and other investigators' study findings indicate that many drug "suppliers" do not fit into the traditional image of "dealers" in drug markets (Blum, 1972; Dorn, Murji, & South, 1992; Coomber & Turnbull, 2007; Jacinto, Duterte, Sales, & Murphy, 2008; Coomber & Moyle, 2013). These suppliers typically do not identify themselves as "dealers," but instead understand their drug distribution as sharing with people they know. These types of suppliers are in fact engaging in the types of drug distribution activities that fit our understandings of social supply. Yet, in the U.S., the concept of social supply has not yet penetrated academic or public discourse. In the United Kingdom, the concept of social supply has entered the political arena and triggered discussions concerning policy reform to change criminal sentencing to proportionately address various levels of drug supplying (Coomber & Moyle, 2013).

Coomber, Moyle, and South argue that while drug scholars in the UK have to some extent accepted the general process of the normalisation of drug use, "this process has not, thus far, been widely examined in relation to drug supply or drug markets" (2016: 261). Further, Parker, Aldridge, and Measham (1998) and later South (2004) and Coomber (2004) argue that the normalisation of drug use is also conducive to a relative normalisation of drug supplying. Murphy, Reinarman, and Waldorf (1990) utilised Matza's (1964) conceptualisation of drift to explain pathways into cocaine distribution as committed users taking "short steps down a familiar path" rather than a long leap down an unknown road. Using illegal drugs regularly is the first step of the journey toward needing to access drugs and to acquire them safely, while trying to obtain the best possible quality and price, thus moving other trusted users into social supply roles.

In the U.S., with the notable exception of the increasing acceptance of medical and to a lesser extent recreational cannabis use, the go-to response to illegal drug use continues to be criminalisation and punishment. To this end federal drug legislation places drugs in different "schedules" of the Controlled Substances Act (CSA) based on medicinal value, harmfulness, and potential for addiction and abuse. For example, LSD and heroin are classified as Schedule I. Prescription stimulants, cocaine, and certain prescription narcotics (i.e. Fentanyl, oxycodone, and morphine) are included in Schedule II. Examples of Schedule III drugs include combination narcotic products (Vicodin, Tylenol with Codeine), anabolic steroids, and ketamine. Schedule IV drugs include benzodiazepines and other prescription sedatives, and Schedule V includes certain cough preparations. Within these schedules, penalties for "trafficking" are generally quantity-related or based on prior offenses. For example, cocaine trafficking can result in five years to life in prison depending on the quantity seized and whether or not it is a first offense. Trafficking prescription stimulants is punishable by no more than 20–30 years, depending on prior offense history. However, in the latter case, the law does not specify quantity considerations, and rather clusters "any amount of other Schedule I and II substances" (i.e. other than cocaine, fentanyl, heroin, LSD, methamphetamine, and PCP) into a generalised category. (For more information on drug scheduling and penalties, see: Chapman et al., 2015; Drug Enforcement Administration, "Federal Trafficking Penalties" and Title 21 United States Code (USC) Controlled Substances Act).

These laws to some extent apply different penalties for distinct types of drugs and specific quantities, but they do not differentiate types of dealing. For one, there is great ambiguity in defining "trafficking" regarding the "other" Schedule I and II drugs for which no quantity-based parameters exist, including prescription stimulants. Secondly, legislation does not specifically distinguish between "dealing" (selling drugs for a monetary profit) and "social supply" (sharing drugs to gain or promote social benefits). Essentially, a college student who gives a friend a few free Adderall pills to help improve school performance could conceivably receive the same penalty as a first-time offender who sold four hundred grams of cocaine. The language of the law creates a confounding dilemma for applying penalties to social suppliers of prescription drugs. To further complicate the matter, individual states have different statutes regarding prescription drug trafficking and diversion, and often include "possession with intent to sell" within the parameters of "trafficking" even if no money is exchanged (National Alliance for Model State Drug Laws, 2009). Given the ambiguity in the language of U.S. law and state to state variances in statutes, it would make sense for the U.S. to follow the international trend towards proportionality in sentencing as a way of working toward a more fair and balanced approach to convictions and sentencing guidelines.

Some of the various mechanisms of prescription drug diversion (e.g. stealing from medicine cabinets, trading with friends with legitimate prescriptions) have been examined in our own and others' research (Chapman et al., 2015; Inciardi et al., 2009; Mui, Sales, & Murphy, 2013; Wood, 2015). Other studies have considered the prevalence of prescription stimulant diversion and nonmedical use in specific populations (Flory et al., 2014; Garnier et al., 2010; McCabe, Teter, & Boyd, 2004, McCabe, Teter, & Boyd, 2006; McCall et al., 2016; Sembower, Ertischek, Buchholtz, Dasgupta, & Schnoll, 2013). However, the magnitude of diversion on a national level is virtually impossible to quantify. In 2017, the data collection that specifically targets arrests for prescription drug trafficking is minimal, and often focuses on opiates rather than stimulants (Drug Enforcement Administration, 2016; McCall et al., 2016). At the same time, the prevalence of nonmedical use of prescription stimulant (NMUPS) remains a growing phenomenon (Center for Behavioral Health Statistics and Quality, 2016; Flory et al., 2014; Garnier et al., 2010; Kaloyanides, McCabe, Cranford, & Teter, 2007; Lakhan & Kirchgessner, 2012; McCabe et al., 2004, 2006; Sembower et al., 2013; Sepúlveda et al., 2011; Sussman, Pentz, Spruijt-Metz, & Miller, 2006; Teter et al., 2006).

The lack of specified arrest data and the increasing prevalence of nonmedical use reflects the normalisation of NMUPS in the U.S., which differs from normalisation of marijuana and other drugs. Motivations for stimulant use can be understood as emanating from values in "conventional culture" that privilege successful