REALLY USEFUL KNOWLEDGE:
AN EXPLORATION OF THE BOUNDARIES,
CUSTOMS AND FOLK-LORE WHICH GOVERN THE
RECREATIONAL USE OF ILLEGAL DRUGS IN A
SAMPLE OF YOUNG PEOPLE

A PORTFOLIO OF STUDY, PRACTICE
AND RESEARCH

MICHAEL GEORGE

Submitted for the Doctor of Psychology
(Psych D) in Clinical Psychology

Conversion Programme

UNIVERSITY OF SURREY,
October 1995
A PORTFOLIO OF STUDY, PRACTICE
AND RESEARCH

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January 1995
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ACKNOWLEDGEMENTS

This portfolio is the product of many years working in the specialism of Addictive Behaviour. Most of what I know I have learned from the clients with whom I have worked over the years and my first debt of thanks goes to all of them.

Special thanks also to my friend and colleague Alan Rosenbach, whose support and critical appraisal of the work in progress has been invaluable. Thanks also to Joan Wild for typing it all out and being patient with me all the while. Thanks to all my colleagues at Options and to the Priority Care NHS Trust who supported my registration for this degree. Thanks especially to Elizabeth Scott-Gliba who trod the path ahead of me and warned me about some of the pitfalls. Thanks also to Lorraine Brackley for organising a graded exposure programme for statistical phobia - with plenty of therapist support.

Thanks to Vibeke and Louise, the gifted and enthusiastic radio-journalists who conducted the field interviews and administered the field questionnaires.

Last but certainly not least, my thanks to Laura Gamble at DAIS in Brighton, whose work on disseminating harm reduction messages through the popular media sparked off this research project. Without Laura there would be no “Really Useful Knowledge”.

1
PERSONAL STUDY PROGRAMME

Psych D in Clinical Psychology

Conversion Programme

Name: Michael George
Date of Registration: 1.10.94
Registration Number: 4612

1. OVERALL AIMS AND OBJECTIVES

1.1 Prime aim of the programme:

1.1.1 To achieve and demonstrate greater professional competence and development in order to enhance the contribution of clinical psychology to the field of addictive behaviour and substance misuse.

1.2 Prime objective of the programme:

1.2.1 To produce a portfolio of study, practice and research that will demonstrate increased competence in each of these areas since completing the M. Psychol degree in clinical psychology.
1.3. **Primary process of the programme:**

1.3.1 A one year personal study programme, tailored by audit to the needs and demands of the substance misuse service in the Worthing Priority Care NHS Trust, personal interests, and current service developments.

2. **ACADEMIC**

2.1 **Aims:**

2.1.1 To enhance academic competence in three specialist areas so as to develop the clinical psychology input to services offered by the Worthing Substance Misuse Service.

2.1.2 To explore and attempt to summarise the literature, research and historical debate which underpins the changing profile of treatment policies and philosophies in substance misuse.

2.1.3 To increase the knowledge base of the substance misuse service and its members and to encourage the development of a theoretical and academic basis underpinning the provision and development of treatment programmes within substance misuse.
2.1.4 To include the attitudinal and political influences which have shaped legislation and service provision in the three critical academic reviews.

2.2 Objectives:

2.2.1 To complete three critical reviews in each of the three specialist areas identified below.

2.2.2 To facilitate appropriate access to information gathered during the programme to other members of the substance misuse service and, where appropriate, the Department of Clinical Psychology.

2.2.3 To develop a working data base of journal articles and other source material for the use of colleagues within the substance misuse service and the Department of Clinical Psychology.

2.2.4 To encourage the exchange of knowledge and expertise through peer support reviews, and internal tutorials on academic aspects of addictive behaviour and its management.
2.3 Rationale:

2.3.1 The field of addictive behaviour and its treatment is overburdened with sweeping generalisations, widely held beliefs, myths and folklore, many of which are rarely researched or validated. Gut feelings, clinical intuition and rigid attitudes abound which inform and mould service delivery and development (or on occasion, lack of it). As a professional and a clinical psychologist one is often asked to comment decisively on issues such as legalisation, methadone maintenance, the addictive personality or the morality of treating self inflicted injuries. These discussions generally generate more heat than light. Much of the work in this portfolio is intended to inform this debate and move away from the emotive towards the logical basis of discourse.

2.3.2 The choice of review areas is not accidental. Academic pursuits which have no practical application are of limited value. In selecting my review areas I have selected topics which have a substantial impact on service delivery, policy and philosophy.
2.4 Plan:

2.4.1 The completion of a 3000 word essay exploring the issues around legalisation, formal and informal decriminalisation with a working title “Legalisation - Winning or Losing the War on Drugs”? The illegality of drug misuse has enormous implications for drug users and the services which they approach for help. Different types of drug elicit different responses based more on emotion than logic. The essay will include a historical perspective. To understand the current attitudinal position it is necessary to briefly map out the path which has been traced in arriving at this point.

2.4.2 The completion of a 3000 word essay investigating theoretical and outcome research on cue exposure. In recent years cue exposure as a treatment for substance misuse has been the subject of much discussion, some investigation, and increasing optimism in a field in which clear treatment gains are rarely demonstrated. Like motivational interviewing and relapse prevention it is a strategy which has been pioneered and developed by Clinical Psychologists within the field of addictive behaviour. Its theoretical underpinning arises both from classical and operant conditioning and it has been used successfully both in the treatment of alcohol and drug dependence.
2.4.3 The completion of a 3000 word essay on methadone maintenance -
What are the goals and are they achieved? No single treatment
intervention has attracted more debate than the use of methadone
hydrochloride in the treatment of opiate addiction. Since its first
description by Dole and Nyswander in New York during the mid
1960’s its popularity as a treatment strategy has waxed and waned.
Hailed by some as the only realistic harm reduction strategy and
condemned by others as “no longer a solution to the problem but
part of the problem itself” by others, the debate continues to thrive.
I will attempt to explore the motivational and psychological
properties of methadone treatment rather than dwelling on its
biochemical properties in great detail.

2.4.4 Registration with the University of Surrey library and use of existing
facilities at the Post Graduate Medical Centre library, Worthing
District Health Authority, and the St. George’s Hospital Medical
School library.

2.4.5 To update on the quality and audit aspects of service development
and service delivery by regular attendance at the South Thames
Regionwide Substance Misuse Quality Assurance and Audit Forum
and presenting clinical and audit topics for discussion.

2.4.6 Regular attendance at the Regionwide Special Interest Group for
clinical psychologists working in the area of addictive behaviour
(which I chair) and providing and organising presentations on psychological aspects of substance misuse and dependence.

2.4.7 Attending the lectures provided by the conversion year at the University specifically designed for students enrolled on the D. Psychol programme.

3. **CLINICAL**

3.1 **Aim:**

3.1.1 To increase personal professional competence.

3.1.2 To develop the services offered by the substance misuse service in Worthing.

3.2 **Objectives:**

3.2.1 To present a dossier on clinical activity as evidence of increased clinical competence.

3.2.2 To describe service developments undertaken within the framework of psychological management and audit.
3.2.3 To encourage the development of new treatment modalities and interventions within the field of substance misuse.

3.2.4 Access the skills of other professionals in the multi-disciplinary provision of treatment programmes.

3.2.5 To promote the appropriate use of psychological interventions by non-psychologist professions within the Health Service, Social Services, Probation, and Voluntary Agencies.

3.3 Rationale:

3.3.1 The traditional delivery of substance misuse services relied heavily on individual counselling sessions, usually conducted by health professionals, with addicts on an outpatient basis. The limited effectiveness of this form of treatment, combined with the exponential increase in service demand over the last 20 years has lead to radical changes in current and future service delivery. It is now recognised that a wider field of professionals and non-statutory agencies will have to be involved in the provision of drug and alcohol treatment and that effective inpatient and group treatment modalities must be explored and developed. Substance misuse services can no longer be a secondary level specialism with access only through formal channels of referral. It is no longer simply the domain of "experts".
3.3.2 The clinical component of my dossier will develop the theme of diversification away from specialist face-to-face contacts and explore the challenges posed by shared care with general practitioners.

3.3.3 It is widely accepted within the health service now that the regular audit of service output is both necessary and desirable in establishing a justification for current levels of provision and supporting bids of new development. As both a clinician and a manager I am trying to develop and refine accessible and useful ways of documenting the quantity and quality of output using both process and outcome variables.

3.4 Plan:

3.4.1 To document, research and develop the involvement of general practitioners in the shared care of clients with addiction problems. Historically there has been some reluctance for general practitioners to “prescribe for addicts” and this has mischievously been compared to giving bottles of vodka to alcoholics. Whilst there are well documented cases of exploitation, manipulation and deception, there are strong arguments for the involvement of primary health care services in the treatment of drug addiction. Guidelines on GP
involvement exist, and if implemented reduce manipulation and
maximise effectiveness in shared care strategies.

3.4.2 To conduct a survey of local general practitioners attitudes towards
the treatment of drug addiction in general practice with special
reference to the concept of "shared care". This will be carried out
by using a brief questionnaire to elicit information on current
practice, policy and attitudes within sample of general practitioners
in the Worthing area.

3.4.3 To develop and document a training package for general
practitioners (and GP trainees) delivered through a lecture
presentation at the Post Graduate Medical Centre in Worthing.
This input will seek to encourage GP's to become involved in the
treatment of addiction by:

1) advising on recognition of drug related problems

2) offering some simple assessment tools

3) encouraging them to recognise that primary staff have
many of the skills required to engage patients with
drug related problems

4) encouraging the development of rational policies to
be observed by all practice staff

5) giving examples of brief case studies to illustrate the points
above.

3.4.4 To document the development of a primary care liaison post in
general practice - utilising funding from the Family Health Services
Authority (FHSA) and District Health Authority (DHA). This will
include the rationale for development of such a post, the job
description and the target duties and responsibilities. Some tools
and variables by which an audit of effectiveness might be conducted
on such a service will also be suggested.

3.4.5 To give, if possible, some account of the implementation of the post
of “primary care liaison worker in substance misuse”, and an
estimate of initial service uptake and outcome evaluation.

3.4.6 To represent, promote and develop substance misuse services at
Trust, District, County and Regional level through strategy and
implementation committees, advisory bodies and the provision of
lectures, seminars and workshops within the Region and beyond.

3.4.7 To continue to work within the parameters of a multi-disciplinary
team and thereby gain experience of different theoretical and
professional approaches whilst at the same time offering a fuller
understanding of psychological perspectives to other professionals
within the team.

4. RESEARCH

4.1.1 Aims

4.1.2 To increase research competence so as to develop the services
offered by the Department or profession.
4.1.3 To increase the knowledge available to the substance misuse service and clinical psychology profession.

4.1.4 To raise awareness within the service and NHS Trust of particular service needs.

4.1.5 To research a topic of personal interest that has been highlighted by clinical work and professional experience.

4.2 Objectives

4.2.1 To plan, implement and report a substantial piece of research into the phenomenon of successful recreational drug use amongst young people in comparison to the problematic drug use of people presenting to drug treatment agencies.

4.2.2 To include a review of published literature related to the research theme of successful recreational drug use.

4.3 Rationale

4.3.1 Recent studies of drug misuse by young people suggest that recreational use of "dance drugs" as well as cannabis and the hallucinogenics has reached almost epidemic proportions.
4.3.2 There is scant but compelling evidence for the long term recreational use of opiate drugs such as heroin. Some interesting case studies are included in the available literature.

4.3.3 Anecdotal evidence seems to show that many young people experience few problems and most feel able to maintain control over their intake. Little work has been done to explore the mix of knowledge, folklore, tribal customs and boundaries which make up the unwritten rules which govern recreational drug use. Yet these informal checks and balances certainly exist. Their successful implementation differentiates the recreational (successful) drug user from the dependent (unsuccessful) drug user. Because the former group seldom approach health care agencies, little is known about them.

4.3.4 Research is most useful to clinicians which informs clinical practice. Much can be learnt about the treatment of dependence through the study of drug users who fail to become dependent. More importantly, sensible and pragmatic prevention messages can be developed from the study of recreational drug use which are likely to be both more credible and persuasive than exhorting young people to “just say no”.
4.4 Plan

4.4.1 To conduct, develop and produce a field study of recreational use in a sample of young illicit drug users.

4.4.2 To explore the boundaries, customs and folklore which govern the recreational use of illegal drugs in a sample of young people.

4.4.3 To use the qualitative research methods of social anthropology to elicit a small set of generalisations that cover the consistencies discerned in the raw data.

4.4.4 To develop a questionnaire intended to verify the core constructs and categories within successful recreational drug use.

4.4.5 To conduct a comparison between questionnaire profiles for a group of non clinical recreational drug users and a sample of "problem users" approaching treatment services for help.
5. PORTFOLIO OUTLINE

5.1 Academic component

5.1.1 A review essay on the debate surrounding the points for and against the legalisation or decriminalisation of illicit drugs.

5.1.2 A review essay on the use of cue exposure in the treatment of substance misuse.

5.1.3 A review essay on the goals, rationale and philosophy underpinning the use of methadone in the treatment of opiate addiction.

5.1.4 Workshop and lecture attendance.

5.2 Clinical component

5.2.1 To document the development of involvement of general practitioners and primary health care teams in the delivery of services to substance misusers.

5.2.2 To conduct an attitudinal survey of general practitioners involvement in the shared care of substance misusers, with special reference to intravenous (iv) drug users.
5.2.3 To document a training input to GPs delivered through the ongoing post qualification training programme at Worthing Post Graduate Medical Centre.

5.2.4 To document the planned development of a primary care liaison post in substance misuse, operating from the Littlehampton area of the Worthing District.

5.3 Research component

5.3.1 Planning, implementing and reporting research into the successful recreational use of illegal drugs in a sample of young people using the qualitative research methods of social anthropology.

5.3.2 To develop a questionnaire to check and validate the core components and constructs which emerge from the field data.

5.3.3 To compare the questionnaire research profile of the recreational drug users with problematic drug users approaching a treatment clinic to identify significant differences or similarities between the two groups.

6. SUGGESTIONS FOR TRAINING EVENTS
6.1 Lectures/seminars

6.1.1 Qualitative research methods.

6.1.2 The role of clinical psychology within the health service management framework.

6.1.3 Successful marketing of psychological services.

6.2 Workshops

6.2.1 Supervision skills.

6.2.2 Working with the media.

6.2.3 Effective presentation skills.
6.3 Other

6.3.1 Looking at the catalogue of work being undertaken by current students registered on the Psych D Conversion Course it is difficult to identify any commonality between all course participants other than their professional background in clinical psychology. It is on this, therefore that I would like to focus in my suggestion for other course inputs. Clinical psychology is no longer one profession but a myriad of professions. It’s strength is its broad based flexibility as a discipline and career and clinical psychologists occupy the most unlikely niches within and outside the health service. It is perhaps to this phenomenon that we could turn our attention in one or a series of discussion groups exploring the loss of cohesion and common identity within the profession, the attitudes of course participants to careers and career structures, alienation from traditional psychology departments, fears of becoming de-professionalised or de-skilled and similar professional identify issues. A focused discussion group of this kind might give an interesting perspective across the range of newly qualified and established clinical psychologists within the profession.

Signed ...........................................................................................................
Participant

Signed ...........................................................................................................
Head of Clinical Psychology Dept

Signed ...........................................................................................................
Course Director
PROHIBITION, DEVIANCY AND EXCESS:
WINNING OR LOSING THE WAR ON DRUGS
"The Government rejects the view that legalisation (or
decriminalisation) of some or all illegal drugs is a responsible way of
reducing drug related crime.... In the government's view, this is to
concentrate the argument too narrowly around the issue of criminality.
of course, taking certain laws off the statute books brings about a
technical reduction in crime figures. Yet no one would suggest
decriminalising armed robbery or assault on that basis. The issue lies in
the danger posed to individuals and to the community by the activity in
question....."

"Tackling drugs Together - a consultation

(HMSO, 1994 p.3)

"After decades of study, the time has come to state that prohibition is a
total failure without any merit. On the institutional, social, erroneous,
civil and cultural level it is a plague, produced by enoneous laws and
conditions which can only be cured by abolishing these laws and
fighting against those philosophies that threaten new disasters of every
kind..."

M. Panella (M.E.P)
Drug Policy Foundation Conference
Washington, 1989

"...Our view on drug problems reflect and shape the reality they
address. They have major consequences for policy and resource
allocation, and real impacts on the people we are dealing with - people
who use drugs..."

(Stimson, 1990 p.122)
INTRODUCTION

In this essay I will attempt to identify the polarised positions which are vociferously espoused on the subject of prohibition. The implications of the opposing views of the two politicians cited above are highlighted by Stimson, a sociologist whose work maps the impact of attitudes and beliefs on policy and, in turn, the effect of policy on populations of substance users.

I will also explore the way in which the prohibition of an activity and the "amplification of deviancy" (Young, 1973) which prohibition implies, serve to exacerbate in some the frequency, and in many the harmfulness of that activity.

In taking a historical perspective of prohibition I will attempt to delineate the link between culture, policy, legislation and their effect on the harmfulness of substance use. Specifically I will be addressing the following questions:

1) Does liberal supply lead necessarily to an increase in substance use and related harm?

2) What informal cultural control mechanisms exist and how well do they work in a deregulated market?

3) Do prohibitionist policies reduce morbidity and prevalence?
Turning from the "macro" issues of policy and politics, I will turn to the impact on substance users of the legal status of the drugs (including alcohol) which they use. The axis of normalisation - deviancy amplification is of great importance in determining the attributional and motivational state of a substance using individual. The attitudinal framework surrounding substance use affects individual responses to their own and other's use of substances.

THE FALL AND RISE OF PROHIBITION

The non-medical use of psychotropic substances can be seen (and has been seen) in a number of ways: Is it a moral disease that affects the individual's will requiring, presumably, interventions centred on confession and repentance? Is it a medical problem with a clear aetiology, prognosis and treatment, exonerating "sufferers" from personal responsibility (Davies, 1992)? Is it a criminal problem - a matter for legislation and enforcement (Tackling Drugs Together HMSO, 1994). Is it merely a clash of value systems - majority distaste towards a minority pastime?

Is it a social problem - a reflection of structural disadvantage and alienation (Young, 1973; McDermott, 1992)? Is it the final common pathway of various psychological traumas such as childhood sexual or physical abuse, separation, inadequate parenting? (Royal College of Psychiatrists, 1987)? Or is it no more or less than a public health
problem, like infected water supplies or air pollution (Stimson, 1993)? These views, in isolation or combination have prevailed and dominated at different times. Substance misuse does not exist in a vacuum. Individual behaviour is affected directly or indirectly by the climate which surrounds it. People have, over the years, been seen variously as victims, invalids, sinners, criminals or nuisances.

ALCOHOL PROHIBITION IN AMERICA

The best known episode of alcohol prohibition occurred in North America between 1920 and 1933. Prohibition “attempted to remove alcohol from the American culture without providing any alternative form of satisfaction” (Gossop, 1982). The retrospective consensus is that the outcome was disastrous. Gossop writes that by 1930 more than half a million Americans had been arrested and sentenced to more than 33,000 years imprisonment. Public and politicians alike flaunted the “liquor laws”. Al Capone, spearheading the Mafia infiltration of North America on the back of prohibition simply stated “I make my money by supplying public demand. If I break the law, my customers, who number hundreds of the best people in Chicago, are as guilty as I am”. (Cited in Gossop, 1982 p.175). The police, given the unenviable task of prosecuting an unenforceable law, grumbled loudly. Sixty years later, a police officer lamenting the unenforceability of the cannabis laws in the 1990’s would say “we are manufacturing criminals and creating a crime without a victim”. (Fraser and George, 1992).
themes of prohibition seem to resonate down the decades. Illegal alcohol, consumed in vast quantities, caused massive increases in alcohol related morbidity and mortality and in Chicago the rate of deaths from alcoholism rose by 600 per cent during that period. This disastrous legislation was inevitably repealed in 1933 and gradually normality re-established itself, save for the tenacious foothold of the Mafia which remained. They, however, had to find more profitable ventures to occupy their attention.

THE PROHIBITION OF OPIATES
The supply of opiate preparations was unrestricted in Great Britain until the Pharmacy Act of 1868. Until that time a bewildering variety of draughts and nostrums to ease pain, promote sleep and generally get the population of nineteenth century Britain through the day (and night) were available from chemists, druggists or prepared at home from the raw materials. The basic ingredient, the opium poppy (papaver somniferum) had been available since time immemorial. The stronger compound, Morphine, had been isolated in 1804. Preparations such as Laudanum were used endemically - Opium was indeed the religion of the people (Berridge, 1977). Main producers of Opium, China and India competed for trade as use increased, resulting in the pernicious "opium wars". Despite the tighter controls on supply resulting from the pharmacy act, opium use became more visible with widespread Chinese immigration to the USA and Europe.
More powerful preparations and methods of use led predictably to the emergence of a hard core of addiction to opiates. The hypodermic syringe was invented in 1845 and Diamorphine (Heroin) was developed in 1898. (Intravenous morphine use was popularised in the writings of Arthur Conan-Doyle as a despicable habit of his detective Sherlock Holmes - but one which aided concentration).

The Defence of the Realm Act (DORA) aided the first world war effort by introducing licensing hours for alcohol, and restricting the importation and supply of cocaine.

In 1920 the Dangerous Drugs Act made it necessary to have an import licence for Opiates and other "illegal" drugs, while imposing a strict control on prescribing and dispensing. In 1926 the Rolleston report found only a handful of therapeutic opiate addicts and some medical and dental professionals who had taken too much of their own medicine. He recommended a pragmatic and humane open-ended prescribing treatment for addicts which became known as the "British System". In 1965 the Brain Committee found a disturbing trend towards young male deviant users of imported Chinese heroin. Opiate addiction was finally moving onto the streets (D' Alarcon and Rathod, 1968).

This growing visibility resulted in the most comprehensive and prohibitionist piece of drug legislation - the 1971 Misuse of Drugs Act, which classified all the (then familiar) illegal drugs and specified
guidelines on fines or terms of imprisonment for possession or supply.

In 1965 the total population of Heroin addicts was estimated between 2,000 and 2,500 (Teff, 1975) in the UK. In 1993 the current total of Home Office Notifications stands at 27,395 (HMSO Statistical Bulletin) and a conservative estimate of true prevalence would suggest a multipayer of at least 5. (Hartnoll et al, 1985).

The increasingly stringent legislation intended to control the use of Opiates has been at worst counter-productive and at best ineffective against the rising tide of opiate use in the United Kingdom. The civil war against drugs, while creating many casualties, can claim few victories. Paradoxically, the government green paper “Tackling drugs together” (1994) focuses on getting drug use out of the penal system - a problem created by the faulty solutions of the 70’s and 80’s. Davies (1992) observes dryly

“unfortunately, our own legislators look for advice with frightening regularity to nations where the attempt to control drug use has had the most grotesque and spectacular consequences, in the mistaken assumption that they have thereby demonstrated some sort of competence in this field....” (prologue p.9)

THE PROHIBITION OF CANNABIS

Cannabis holds a unique position among illicit drugs. No other substance has provoked such a widely divergent range of social legal and political responses especially in Europe.
Cannabis was first prohibited in the United States in 1937 as a result of a single minded campaign by Commissioner H.J. Anslinger of the Federal Bureau of Narcotics. This “relatively mild drug” (Trebach, 1982) became lumped together with more powerful and dangerous narcotics such as heroin. Successive carefully researched reports commissioned by scientific, political and legislative bodies throughout the world have however presented a less bleak view of cannabis. In 1904 the Indian Hemp Commission submitted their report to the British Government. It concluded that:

“the evidence shows the moderate use of Ganja not to be appreciably harmful, whilst in the case of moderate use of Bhang drinking the evidence shows the habit to be quite harmless” (p.115).

In 1944 the La Guardia Committee, commissioned by Fiorella La Guardia, the Mayor of New York, concluded that cannabis was not addictive in the medical sense of the term, had no effect on the user’s personality and was not a cause of crime or juvenile delinquency. Similarly the Wootton Committee in a report on cannabis commissioned by the British Government found no evidence that cannabis use led to crime (other than the crime of use itself) or aggressive behaviour, nor that it produced psychotic states in otherwise normal users (Wootton Committee, 1968). The report nevertheless concluded that cannabis is a “dangerous drug although a less physically dangerous one than amphetamines barbiturates or alcohol....” (p.106).
The US Schafer Report in 1972 unambiguously recommended the ending of criminal penalties for private use although it did not favour legalisation. The same year the De Lain Commission in Canada felt that the law on cannabis had created disillusionment with law and legal institutions as well as the process of government generally. However unease about harmful effects led the Commission to recommend a continuing policy discouraging its use by means of a process which involves a more acceptable cost than present policies to the individual and society.

This echoed the earlier findings of the British Advisory Council on the Misuse of Drugs (ACMD) which in 1968 concluded that the wider use of cannabis should not be encouraged. A later report from the ACMD in 1982 was equally cautious but still inconclusive.

Negrete (1988) warned against the growing complaisance spreading like the cannabis epidemic itself. In an influential commentary on the cannabis debate, he concluded that despite the potential physical, neurological and psychiatric harmful effects of the drug, the political and scientific community appeared to be losing interest. The reasons for this, he argued, were that cannabis use had become so widespread that it had gained tacit social acceptance and that the increase in the use of other illegal drugs over the past twenty years had made the use of cannabis seem comparatively harmless.
Although doctors continue to argue over cannabis (and from a medical viewpoint it cannot be given a clean bill of health) it is certainly no longer regarded as deserving the demon drug status assigned to it by Anslinger. However the use, possession and distribution of cannabis remain criminal offences in the United Kingdom under the Misuse of Drugs Act 1971. In 1990 there were 44,922 convictions or cautions for drug offences, most of which related to possession (ISDD, 1991). Nearly 90% of all drug offences concerned cannabis. Known cannabis offenders doubled between 1986 and 1990 and rose as a proportion of all drug offenders. This may have more to do with police activities than drug use trends.

In 1979 and 1982 the ACMD recommended that herbal cannabis and cannabis resin should be re-classified to Class C (they are currently Class B) and that possession should not be an arrestable offence. This recommendation was ignored by government.

In 1991 Justice (British Section of the International Commission of Jurists) published its report ‘Drugs and the Law’ under the chairmanship of His Honour Judge Peter Crawford QC. Regarding cannabis the report gives the following recommendation

"we consider that it is not feasible or desirable to remove cannabis from control under the Misuse of Drugs Act. At the same time we think that it is inappropriate for such a high proportion of public resources to be focused on its use when by comparison with other Class A and other Class B drugs it is significantly less harmful. We accordingly recommend that
cannabis and cannabis resin should be re-classified as Class C drugs" (p.90).

In practice official police attitudes have become much more flexible in relation to police cautioning towards unlawful possession (Monaghan, 1991); likewise courts are likely to impose non-custodial sentences for simple cannabis possession. Recent cases would indicate that courts consider a custodial sentence only after the fourth or fifth conviction.

POLITICAL VIEWS ON CANNABIS

Whilst advocating lower penalties than previously, the Wootton Committee recommended that possession of cannabis should continue to be punished by a fine of 100 pounds or four months imprisonment. The then Home Secretary J. Callaghan rejected this modest and hardly permissive proposal arguing in the House of Commons that:

"to reduce the penalties for possession, sale or supply of cannabis would be bound to lead people to think that the government takes a less serious view of the effects of drug taking" (p.91).

Nearly twenty five years later, Margaret Thatcher was telling the World Ministerial Summit to Reduce the Demand for drugs and combat the cocaine threat:

"...we should make it absolutely clear that you can’t beat drug taking by legalising drugs. That is the way to destroy young lives, ruin families and undermine society itself. Our task is to protect young people not deliberately expose them to danger. I can assure you that our government will never legalise illicit drugs, hard or soft...."  
Margaret Thatcher (1990, p.91)
Politicians are united in their opposition to cannabis. This may be because they see it as potentially undermining society. It could also be that they appreciate that cannabis use is still a minor activity in every age group and that decriminalisation attracts little support from the electorate.

Opinion polls have uniformly concluded that only 8-12% of the general population favour reducing cannabis related penalties or legalising the drug. Even in the 15-24 age group suspected to contain the highest percentage of cannabis users, 71% disapprove of legalising soft drugs (Royal College of Psychiatrists, 1987). As a consequence in the UK only the Green Party support legalisation of cannabis: most British MPs irrespective of party would agree that there are no votes in cannabis.

PROHIBITION AND HARM MAXIMISATION

“.....The final requirement is to recognise that harm results not only from the drug misuse itself, but also potentially form measures taken to combat it.....”

(Pearson, 1992 p.47)

“.....there is an intimate relationship between a drug policy based on prohibition and criminalization of drug use, and the difficulties in development of effective preventative and treatment approaches to addiction....”

(Drucker, 1992 p.1129)
To expose the repetitive fallacies of prohibition is easy. In 1984 the Misuse of Solvents act drove the glue sniffers away from (relatively) less harmful glue-based volatile hydrocarbons to much more dangerous aerosol based products including butane and lighter fuel - deaths per year in the UK increased from 80 to 140 over the next eight years (Resolve, 1993).

The criminalisation of alcohol in 1920's America led to an increase both in morbidity and mortality (Gossop, 1982) although, notably, the overall consumption of alcohol fell during the prohibition years. A general rule seems to emerge that, while prohibition may reduce the overall frequency of a given behaviour, the dangerousness to the individual and to society for those who persist, increases dramatically.

In Scotland during the 1980's strictly enforced laws banning the sale of injecting equipment by pharmacists resulted in HIV sero prevalence rates of over 60% in local injecting populations - up to 10 times the equivalent rate in England, where pharmacists were allowed and even encouraged to provide sterile equipment. Opiate related deaths in the UK and Europe are attributable largely to the unknown and variable concentration of heroin in street supplies leading to accidental overdose, infection from self injection, or toxic reactions to the adulterants with which street drugs are “cut”. All of these causes arise directly out of the illegality of the drug rather than out of the drug itself.

In America, where anti-prohibitionist rhetoric is all the more strident
since the evils of prohibitionist influences abound, the commonest sort of drug-related death by far is now murder. (Miller, 1991).

The phenomenon of prohibition and harm maximisation is not exclusive to the field of substance misuse. In 1885, homosexuality was an illegal act and stiff penalties were imposed for successful prosecutions. Only in 1967 were homosexual acts made legal between adults over 21 years of age. In 1965, Eysenck and Rachman devoted a chapter in a contemporary textbook to “the treatment of this disorder” - advocating the use of faradic (electrical) as opposed to chemical aversion conditioning. The personal experience of homosexuality becomes, under these conditions, associated with guilt, anxiety and secrecy. Apprehension of deviant acts (ie getting caught) becomes couched in terms of disease, or loss of control by the individual seeking to exonerate him or herself. In a telling article (Simpson, 1994) on sexual addiction, one subject reports the experience of explaining his behaviour to a GUM clinic doctor when being treated for a sexually transmitted non-specific urethritis (NSU) for the second time in one month:

“He asked me how I caught it and I told him that I went cottaging. He was clearly shocked. I suggested that I wasn’t able to help myself. I didn’t want to have to deal with his disapproval. In the end he insisted that I make an appointment to see a health adviser to get some help for my “problem”. He definitely seemed to see the NSU and the cottaging as both diseases which needed treatment” (pp 68-69)
Promiscuity and unsafe sex were traditionally associated with gay men until the emergence of the HIV epidemic forced the issue out of the closet. Media exposure helped to disempower the taboo and high risk behaviour was radically modified.

This points to the relevance of deviance amplification theory. (Taylor and Taylor, 1973; Keane et al, 1989). It has been suggested that a positive feedback system may unintentionally promote additional deviance. The model works thus: the action taken by society (to behaviour such as homosexuality or drug taking) and the resulting self-perception of the individuals defined as deviant leads to their isolation, alienation and, more importantly, to their “encapsulation” within a deviant group, culture and behavioural repertoire. Deviant groups tend to develop, promote and escalate their own values and behaviours. Society’s forceful response to this entrenchment usually further amplifies the deviance and a vicious circle of attack and defence is created.

The final word in this section goes to the courageous American psychiatrist Norman Zinberg who pioneered the idea of an acceptable level of illicit drug use during the 1970’s. He insisted that the socialisation or normalisation of any behaviour relied on 1) widely available appropriate role models and 2) the availability of good quality education. He gives (1984) the endemic use of alcohol as an example of the former and the provision of sex education for the latter. Illegal
drug use is removed from both these sources of positive influence and in this way does not become socialised and built into the cultural and normative constraints of the society within which it exists - left out in the cold, it feeds on its own sub-culture. It becomes the defining function of the group and excess is promoted in defiance of the larger opposing counter-culture.

**PROHIBITION AND EXCESS**

Prohibitionist policies lean heavily on the assumption that a free (or freer) market will promote epidemic use. The evidence for this is equivocal. A recent article by Reuband (1994) challenges this view. On the basis of survey data and estimates of cannabis and hard drug use in Western European countries, the author concludes that Liberal countries do not have higher or lower rates than countries with a more repressive policy. Interestingly, he goes on “Informal social norms seem to be of greater relevance than formal legal norms and availability of drugs”. However, if clear-cut relationships between drug policy and prevalence levels cannot be established, it does appear that injurious patterns of use and physical complications are promoted by prohibitionist drug policies.

The ubiquitous “Dutch experiment” has not turned out to be the disaster that it’s critics predicted. Decriminalising cannabis has not led to an overall rise in the consumption of marijuana, nor has there been a marked rise in heroin addiction (people moving to more potent drugs to
re-introduce the element of illegality and excitement). Indeed, at 0.14 per cent, the proportion of the population that uses drugs in Holland is lower than in Britain, Germany, Denmark and Italy, all of which have more stringent and prohibitionist laws and policies (Concar and Spinney, 1994).

CULTURAL CONTROL MECHANISMS

The discussion thus far has suggested that prohibition does not necessarily lead to a decrease in prevalence and morbidity, nor that more pragmatic and laissez-faire policies necessarily lead to epidemic use and misuse. It remains to review some of the cultural controls which maintain appropriate use without formal legislation.

Water buffaloes browse on opium poppies, wild elephants gorge themselves on fermented fruits, koala bears become dependant on a diet of eucalyptus leaves through feeding at the breast and the yellow ant licks the hallucinogenic secretion from the abdomen of the Lomechusa beetle in exchange for the provision of food, care and crèche facilities - often to the detriment of the ant colony (Spinney, 1994).

If the search for chemically altered states of consciousness is indeed a natural phenomenon, the laws of species survival would suggest the development of inbuilt control mechanisms - an ecology of intoxication.

The mystical use of hallucinogenics is documented by Castaneda (1968). In this example the American Indian Yaqui tribe use peyote
(mescaline) and other fungi to become "men of knowledge." Control and appropriate use are highly valued. The use of drugs is seen as a means to an end - not an end in itself.

Watson (1991) describes the use of betel (Areca Catechu) amongst the Biwat people of Papua New Guinea. Her study documents a culture in which

"everybody has the opportunity to produce and trade drugs; indeed it is mandatory to do so. Yet despite the resulting huge surpluses of betel and tobacco, actual consumption levels appear quite moderate". (p.11)

A high value is placed on controlled use (indicated by increased productivity) and "betel drunkenness" is censured. The use of the drug at formal occasions such as deaths and marriages, the settlement of disputes and love magic is strongly discouraged - a similar injunction perhaps to drink - driving laws in Europe. Watson cites this as a significant example of sustained demand-side control in the absence of any supply side control - achieved wholly without legislation.

In the Northern Territory of Australia, the indigenous Aboriginal men drink Kava - a psychoactive plant substance from the plant Piper Methysticum. In these communities a self-imposed ban on the consumption of alcohol is promoted by the elders to decrease the risks associated with the simultaneous ingestion of both drugs (d'Abbs, 1991). The author concludes "...there is a temptation in the past of
policy makers to see only social disorganisation in Aboriginal communities and to brush aside those local control mechanisms that do exist and impose mechanisms of their own” (p.32).

Other communities find the arrival of a “new” drug disrupts hitherto stable economies and behaviours incorporated around familiar drug use. Hamid (1990) documents the disruption of the Afro-Caribbean cannabis economy of New York city by the emergence of the crack-cocaine market. Rastafarian religious injunctions were disregarded, long standing alliances overturned and “turf wars” followed. This “crack-related deculturation” proved ruinous to the established ecosystem and drug related harm spiralled exponentially.

It is not, therefore, only the imposition of external legislation which disrupts cultural ecosystems. Unfamiliar substances, until (eventually) incorporated into the societal normative values, play a similar role in disrupting natural systems. Arguably prohibitionist policies hinder rather than help this process of incorporation by denying discussion, education and appropriate role modelling.

CONCLUSIONS

This essay has attempted to draw together a wide range of academic influences. Clinical and social psychology, sociology, ethnology, criminology and epidemiology all have an important contribution to
offer to the debate on prohibition. However, key themes do emerge
from this global and historical perspective of drug use and misuse.

There is some evidence that abundance supply does not necessarily lead
to epidemic substance use (Watson, 1991; d’Abbs, 1991; Castaneda,
1968). Similarly substance use itself should not necessarily be seen as
pathological, criminal or deviant, but can instead be interpreted as a
logical response to prevailing environmental circumstances. This view
is espoused by the “Social Deviancy Theorists” such as Jock Young and
Howard Becker.

Some activities can be made wrong simply by the imposition of
deterrent legislation. In some cases, such as Cannabis possession for
personal consumption or homosexual activity, this criminalisation
increases the potential harm and risks associated with the behaviour.
Anti-drug legislation has left a historical trail of inconsistencies such as
the legal status of addictive and potentially hazardous drugs like alcohol
and tobacco, while imposing deterrent sentences on the use of Cannabis
or Magic Mushrooms.

Cultural (informal) controls can be shown to be as effective as formal
legislation. However, this is best demonstrated in long established
cultures where the use of particular drugs has become woven into the
customs, rituals, and folk-lore of the indigenous population.
Extrapolation of this “self control” effect to the transient, mobile and
dynamic contemporary youth culture in developed societies is therefore limited and should be done with caution. It may take centuries for a static culture to successfully incorporate a single drug substance.

Finally, the apparent failure of prohibition and deterrent legislation in reducing the demand, supply and use of illegal drugs prompts the vigorous search for more pragmatic and effective solutions. Prohibition has not only failed in this endeavour, but has introduced the black market which brings with it organised crime, the adulteration of substances, violence and inflated drug prices. All of these impact negatively on the individuals who persist in using illegal drugs.


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CUE EXPOSURE IN THE TREATMENT OF DRUG AND ALCOHOL DEPENDENCE - THEORY AND PRACTICE
“Cognitive Therapy Serenity Pledge”

I pledge that I will strive to gain the strength to stay away from those drug triggers that I can avoid, the serenity and know-how to cope with those drug triggers that can’t be avoided, and the wisdom to know the difference...”

(Beck et al. 1993 p.309)

In recent years, cue exposure as a treatment for substance misuse has been the subject of much discussion, some investigation, and increasing optimism in a field in which clear treatment gains are rarely demonstrated. Like the techniques of Motivational Interviewing (Miller, 1983) and Relapse Prevention (Marlatt and Gordon, 1985), cue exposure has been developed by psychologists working in the field of addictive behaviour, and is rooted in Cognitive Behavioural theory.

While the theoretical model of Cue Exposure is relatively straightforward, recent studies have added uncertainty to the explanation of how it works, why it works or more recently (Drummond et al, 1990) whether it works at all.

In this essay I will briefly summarise the theoretical basis of cue-exposure as a treatment modality. I will illustrate examples of cue related behaviour and attempt to offer responses to the following questions:
Are conditioned responses appetitive or avoidant in nature?

What are the most important cues in exposure treatment?

Do individual differences exist in cue-reactivity?

Does cue-reactivity decrease in the absence of specific treatment?

Are cue-reactivity and "craving" one and the same thing?

Finally, I will review the recent literature on the affectiveness of cue exposure in the laboratory and its ability to transfer into the "real world".

The conditioned response (CR) model of relapse was first proposed by Wikler (1965), based on the observation that heroin addicts, even when abstinent for some months, were more likely to relapse in an environment where drug use had previously occurred. In Wikler's model the physiological symptoms of withdrawal become paired by association with the Environmental cues or stimuli. Thus the experience of withdrawal and its associated craving, originally the unconditioned response, become conditioned responses to the conditioned environmental stimuli:

\[
\text{PHYSIOLOGICAL (UCS)} \rightarrow \text{WITHDRAWAL (UCR) EXPERIENCE}
\]

\[
\text{ENVIRONMENTAL CUES (CS) OR STIMULI} \rightarrow \text{CONDITIONED WITHDRAWAL CRAVING (CR)}
\]
The application of this theory to the process of drug use would suggest a hierarchy of cues varying in potency and evoking a varying range of conditioned craving responses.

Clinical and anecdotal experience would suggest that this is the case. Novice abstainers are encouraged to “stay away from drinking places and faces”. The AA fellowship employs evocative pugilistic expressions for high risk situations such as “the front line” or “another round in the ring”. At this stage at least three distinct cue exposure phonema can be identified:

**Cue Avoidance**

Beck et al (1993) offers the following advice on coping with cravings.

> “Patients can remove themselves from the cue-laden environment. They can take a brisk walk, visit a friend, or go for a drive. One of our patients found the public library an excellent place to escape in order to reduce cravings.....” (p.160)

It is logical to suppose that little or no misuse of drugs or alcohol had taken place in the public library and that this was therefore a “trigger-safe” environment.

**Cue Seeking**

Stewart (1987), in a telling personal account of Heroin addiction writes:
"The command to change seemed ludicrously grave and quite impossible to carry out. Nevertheless I got on with the cure, motivated, like many others, primarily by impecunity. I waited impatiently for the moment when I could relapse..." (p.83).

Pre-contemplators and contemplators who are pushed into recovery by external coercion may well find “excuses” to relapse and stumble inadvertently into or engineer high risk situations in a way that is barely a conscious/cognitive process. Some anecdotal examples spring to mind: One problem drinker, recently abstinent, insisted on frequenting his favourite drinking haunt in the hope of encountering a man who owed him some money. Another did exactly the same thing to “prove to his mates” that he could go into the pub and not drink alcoholic beverages.

**Cue Management**

Some cues either cannot be avoided or are only avoided at the expense of the general quality of life. The former category includes internally mediated cues which arise out of thoughts, emotions or physiological states (tiredness, frustration, anxiety etc). The latter category includes all forms of social interaction - for example an abstinent problem drinker might decide to keep away from people who drink and places where alcohol is sold. He or she would effectively shun 93% of the adult population and starve to death.

These situations, therefore, call for cue management (stimulus control) in one form or another.
The technique of cue exposure

Originally described in its application to de-conditioning phobic responses (Freeman and Kendrick, 1960), cue exposure draws on the graded exposure and reciprocal inhibition of Joseph Wolpe. Subjects are exposed to an increasingly potent hierarchy of drug/alcohol related stimuli whilst (as with the behavioural treatment of obsessive-compulsive disorders) the conditioned response is prevented. While phobia treatments seek to reduce anxiety and flight as their cognitive and behavioural variables, cue exposure in the treatment of addiction seeks to extinguish appetitive cognitive and behavioural responses such as craving, using and drinking.

Usually, exposure programmes commence with imaginal cues and graduate to in vivo exposure to increasingly pertinent stimuli such as syringes, videos of people using drugs, glasses of favoured alcoholic beverages to be smelled and handled etc. During these experimental exposure sessions, recordings are made of subjective responses as well as physiological variables such as heart-rate, blood pressure, skin conductivity and temperature, all of which are accepted as physiological correlates of arousal.

As with the traditional behavioural treatment of phobic anxiety, the gradual extinction of the conditioned response is anticipated. Thus, in
principal, the risk of relapse as a result of exposure (accidental or otherwise) to drug or alcohol related cues, is diminished.

However, more recent research into the effectiveness of cue exposure has questioned the simplicity of the theoretical model as laid out above (see for example Drummond et al, 1990). The exact nature of both the environmental stimulus and the conditioned response, as well as the causal relationship between the two, seem to be more complex than was originally assumed. Several methodological and theoretical issues remain uncertain.

**Appetitive or Avoidance Conditioned Responses?**

Some confusion has emerged as to whether the Conditioned Response (CR) is agonistic (appetitive) or antagonistic (aversive) in nature. In the first paradigm, the cue elicits a desire for the positive, enjoyable and exciting effects of the substance. Previous positive reinforcement schedules evoke a positive expectancy effect, thereby increasing the likelihood of responding (see for example Tolman's Theory of Learning in Bolles, 1975).

In the second paradigm, the response is an aversive one - a conditioned antagonistic response which arises out of the negative emotional and physical effects (or to be more precise after-effects) of previous drinking or drug taking. If this response is weakened or extinguished, the protective effect of the antagonistic response will be diminished and
relapse made more likely to occur - a paradoxical effect for a treatment intended to reduce relapse susceptibility!

Laberg's (1986) study of subjective, psychophysiological and behavioural responses to alcohol stimuli offers another interesting example of physiological antagonistic responses which are similar to the antagonistic cognitive responses suggested above. The study records different physiological responses to a "priming dose" (a small amount of alcohol administered to experimental subjects to evoke, among other things the pharmacological effects of the chemical on the central nervous system) of alcohol among "severely dependent" compared to "moderately and non-dependent" subjects. The high dependence group showed a decrease in body temperature while the other two groups exhibited an increase in temperature. The results was reliable and significant. It suggests physiological compensatory (or antagonistic) learning in more chronic drinkers, the purpose of which is to counteract the hyperthermic effects of alcohol.

What are the most Potent Cues?

The role of physical cues (glasses of alcohol, syringes etc) can only be estimated in the context of the subjects' beliefs and expectations. Laberg (1986) confidently asserts:

"The results confirm our previous findings that expectations of alcohol exert greater influence on craving than pharmacological effects of alcohol...." (p.797)
The experimental design incorporated a balanced placebo design which demonstrated that subjects believing that they were being offered alcohol (whether it was actually alcohol or a soft drink) responded more than subjects who believed they were being offered a soft drink (whether it was actually a soft drink or alcohol). This elegant design is somewhat weakened by the sample size (10 severely and 10 moderately dependent drinkers) and the proportion of subjects who “detected the deception”.

Probably the most comprehensive examination of the relative potency of different potential relapse triggers has been done by Cummins et al (1980).

She studied events leading to relapse in 327 addicted subjects (not all were chemical addictions). Cues or triggers were categorised as INTRAPERSONAL or INTERPERSONAL determinants. “Negative emotional states” were most frequently identified in the former category and “social pressure” in the latter. While the authors advise that coping strategies for environmental, cognitive and physiological triggers should be taught, the evidence presented would suggest that cognitive/emotional states are the most “dangerous” - more so than the environmental cues most often associated with cue-exposure treatment. In effect, subjects would benefit more from exposure to anxiety, frustration, fear and unhappiness in a response prevention contingency
than to the more prosaic paraphernalia of relapse.

McLellan et al (1986) report a telling anecdotal account of a subject who extinguished an entire hierarchy of opiate-related cues after seven exposure sessions. On entering the eighth session after a heated argument with a hospital security guard, intense subjective and physiological responses returned immediately to previously de-conditioned cues.

Nevertheless, some of the widely quoted studies of cue-exposure are alarmingly flawed in this way. Take, for example Blakey and Baker (1980) who used a traditional graded exposure technique with six alcoholic subjects: subject one “indicated that tiredness after long hours of work, boredom, the smell of drink from customers, bouts of illness, and travelling home past a particular pub at night were important antecedents...”. The treatment focused on “progressively exposing him to alcohol, without allowing him to drink it”. Again, for subject two, “...the most important discriminative stimuli were opening times particularly at weekends, the presence of friends, the presence of particular fishing friends, being in a pub, boredom, thirst and a hangover...”. Treatment consisted of “sitting in a pub with one or two therapists whilst he and they drank soft drinks....”.

In later subject by subject accounts, treatments pay closer attention (critically, one might observe that they slavishly emulate the reported circumstances or relapse) to the details of important antecedents. One
subject reported temptation when he was in his car during his job and had a delay before visiting the next customer. He was required to drive around at work with alcohol in his car. Yet, as Cummings et al (1980) point out, it is cognitive-emotional states which most frequently evoke relapse responses, not the presence of alcohol. Even Blakey and Baker (1980) note that subject after subject fail to respond to exposure to glasses of alcoholic drink alone.

As well as the well documented classical and operant conditioning paradigm, the authors suggest a cognitive behavioural mechanism which may account for the optimistic outcome in five out of the six cases: The “Cognitive Invalidation of Hypotheses”, they suggest, operates by challenging the firmly held hypothetical belief system about what will happen to them in a high risk situation. The prior belief that they will inevitably relapse is replaced by one of coping, having choices, self empowerment etc. There are few clues as to what are the effective treatment components but, as the authors conclude “... the main point at the moment is that the results have been successful....”.
Individual differences in Cue-Reactivity

Just as the relative potency of cognitive, emotional, environmental and physiological cues is far from established, the subject variability is likewise less straightforward than previously thought.

Implicit in all of the conditioning models of relapse is the notion that the strength and persistence (resistance to extinction) of conditioned responses is governed by the durability of the conditioned stimuli (cues). How robust the conditioned stimulus is depends on such factors as the number of pairings with the unconditioned stimulus, (ie conditioning trials) the number of reinforced trails, the temporal proximity of these events and the similarity of conditioned stimuli to those present during the original learning trial. Niaura et al (1988) review the conditioning model and remark “...it seems reasonable to suppose that length of drug history and consistency of drug-related stimuli present during ingestion, in the absence of active extinction, should relate to the strength of the observed conditioned response...”.

This observation and it’s theoretical basis generates various predictions. Firstly, subjects with longer histories should show greater cue reactivity and resistance to extinction of response. Secondly, stimuli most proximal to the drug related effect (UCR) should elicit the greatest reactions. Thirdly, experimental conditioned stimuli will elicit greatest responses when they are most like the original CS’s - the same drink, the same type of injecting equipment, surroundings identical to the
dealers flat etc. The evidence to support these hypotheses has been equivocal.

McCusker and Brown (1991) published a research report in which they suggest that Eysenckian personality traits of introversion and neuroticism are more predictive of cue-responsivity variance in dependent drinkers than either severity of dependence or number of year’s drinking. This finding supports Eysenck’s (1973) proposition the introverts are more accessible to conditioning and more resistant to extinction than extroverts. (It is also a compelling thought that introverts have been shown to be over-represented in the numbers of chronic alcoholics, thus confusing McCusker and Brown’s outcome).

Twenty-six dependent drinkers and 10 non-dependent controls were subjected to (first) a neutral stimulus and (second) an alcohol stimulus. Alcoholics showed significantly more anxiety than controls and within the experimental group it was the extent of self reported anxiety which mediated the level of craving which subjects reported. Stated simply, more anxious subjects experience more craving, independent of the length or severity of their drinking problem.

The second prediction that proximal events should (in terms of learning theory) generate greater responses than distal events is challenged above by the results of Blakey and Baker (1980). Marlatt and Gordon (1985) in their influential work on relapse suggest that “picking up the drink or drug” is the last behavioural component in a chain of effects which begins with interoceptive stimuli of a cognitive/emotional nature.
Cummings et al (1980) found emotional states far outweighed environmental (exteroceptive) stimuli in analyses of relapse situations.

McLellan (1986) and his colleagues attempted to extinguish conditioned responses during opiate dependence treatment and concluded that “emotional states such as anger, depression and anxiety can elicit and exacerbate conditioned withdrawal and craving”. In their experimental method, significantly, they replace their early procedure of “cooking up” and injecting saline with a second version akin to “systematic desensitisation” incorporating 30 minutes of psychotherapy and deep relaxation training. Exteroceptive stimuli, in other words, were largely replaced by interoceptive stimuli as targets for modification.

The third prediction - the similarity of experimental and in vivo CS’s being influential in treatment outcome - has been widely reported. McLellan et al’s (1986) work deals with some of the problems of converting laboratory procedures into clinical practice. Childress et al (1987) attempted cue extinction treatment with cocaine addicts and found that the benefits failed to generalise beyond the extinction programme. Two thirds of the subjects relapsed within 2 months after treatment (cited in Bellack and Hersen, 1990. Drummond et al’s (1990) comprehensive review of cue exposure criticises many studies for offering inadequate follow up data. These data would, the authors suggest, be “helpful in establishing whether these changes observed in
the Laboratory extended to drinking behaviour in the natural environment”.

The predictions generated by the learning theory model of relapse are somewhat obscured by individual variations which hamper the effort to find robust and effective treatment procedures. McLellan (1986) and his colleagues conclude somewhat resignedly:

“the most evocative stimuli may often be idiosyncratic to the individual and to his particular addiction history...” (p.927).

**Does Cue Reactivity Decrease Anyway?**

Dawe and her colleagues (1993) published a controlled trial of cue exposure in the treatment of opiate addiction. 186 subjects were randomly allocated to one of two inpatient treatment settings. Each group was further divided into a cue exposure or control condition.

Cue exposure and control subjects did not differ in levels of cue reactivity (photographs of either neutral stimuli or photographs of drug-use, drugs, paraphernalia, bundles of £10.00 notes etc). More notably, all groups showed a significant decrease in cue-elicited craving, withdrawal responses, and negative mood. Cue exposure and control subjects did not differ at either 6 week or 6 month follow-up interviews.

The authors suggest a number of reasons for this remarkable finding. One is that the passage of time alone results in de-conditioning regardless of cue exposure. An absence of trials, in other words, serves as a set of unreinforced trials. Secondly, they point out that life in a
treatment centre (residential) is an uncontrolled experiment in cue-exposure anyway. Conversations with peers or attendance at NA meetings may result in a series of unreinforced exposure to conditioned cues.

Monti et al (1987) document a clear order effect after finding a decrease in reactivity to whichever cue was presented later in an exposure session whether an “active” or control stimulus. This led to counterbalanced or reversed ordering in stimulus presentation or (McCusker and Brown, 1991) presenting active stimuli second to elicit the most conservative and therefore robust estimation of differences between active and neutral stimuli.

Lastly, there appears to be a principle of general deconditioning to the laboratory/experimental procedure: These daunting and unfamiliar circumstances may produce a widespread autonomic arousal in experimental and control group subjects alike. As the environment and procedure becomes more familiar, the psychophysiological indices of arousal might well be expected to decrease showing an apparent extinction curve for treatment and control groups alike. However, while the objective measures of cue reactivity decrease, it is not necessarily the case that craving decreases commensurately.

Does Cue-reactivity equal craving?
Because of the vigour with which objectively measurable changes have
been pursued in cue exposure research, it is little wonder that
psychophysiological measures of arousal have been favoured as
experimental variables. There are two major problems with this
approach: firstly it is far from certain that subjective reports of craving
and objective changes in physiological measures such as Heart rate,
Skin conductance, Systolic blood pressure, Diastolic blood pressure,
Skin temperature, Respiration and salivation correlate well. Indeed
even the basic physiological measures show an alarming capriciousness.
Ludwig et al (1974) found a significant decrease in heart rate in
alcoholics exposed to drinking related stimuli, while Mann et al (1987)
found significant increases McLelland et al (1986) found similar
problems with opiate addicts. They found marked physiological
responses to stimuli with no report of subjective craving and vice versa.
Drummond et al (1990) conclude (p.739)

"....it cannot be assumed, as has been previously suggested, that
physiological responses to ARCs (Alcohol related cues) are
covariates of craving. We suspect, however, that the use of the
term ‘craving’ will prove resistant to extinction...”.

Attempts to extinguish physiological arousal in experimental sessions,
even if successful, may do little to reduce the cognitive/affective
phenomenon of appetitive craving if, as appears to be the case, the two
phenomena operate relatively independently.
The second problem in equating physiological cue-reactivity with craving is the equivocal interpretation of the very physiological measures uses: Are appetitive or aversive reactions being extinguished? Niaura et al (1988) report increased self-reports of anxiety and therapist (observer) ratings of tension consistent with the notion that cue exposure in the lab may be perceived as aversive. Little if any attention is paid to the plausible contention that unconditioned (and later conditioned) stimuli have powerful negative as well as positive loadings in the real world experience of addicted subjects. Arrests, violence, physical discomfort, isolation and imprisonment may have accompanied as many learning trials as those reinforced by pleasant or euphoric outcomes. In effect, the paradigm is one of approach - avoidance conflict (Rachlin, 1976) which is characterised by hesitancy, physiological arousal and attempts (where possible) at escape. It is possible that cue exposure, in rendering “dangerous” cues less arousing, paradoxically increases the chance of high risk situations occurring (reduces the chance of them being avoided) and thereby increases the overall probability of relapse.

**Can laboratory treatment be effective?**

Cue-exposure studies are frequently criticised for their lack of adequate follow up (Drummond et al, 1990; Bellack and Hersen, 1990). The deconditioning of conditioned responses during the treatment phase is seen almost as an end in itself, rather than a means to an end. Where long term outcomes are recorded, their findings are usually pessimistic.
(Drummond et al, 1990; Niaura et al, 1988). An ubiquitous challenge is that of generalisation from the synthetic world of the laboratory to the real world. This problem is exacerbated because most of the published treatment and research reports were undertaken early in patient’s recovery in an inpatient setting. Not to do so, however, raises ethical questions. Outpatient cue-exposure subjects could be seen as relapsing because the treatment created strong urges and the patients were not protected from their impulses by a therapeutic milieu. Delayed reinforcement schedules, after all, play an important part in the maintenance of illegal drug use and, to a lesser extent, misuse of alcohol.

Finally, subjects’ cognitive set can effectively invalidate the role-play of cue-exposure: One subject in McLelland et al’s (1986) study of opiate dependent patients undergoing cue-exposure treatment manifested an extraordinary decrease in cue-reactivity from trial one to trial two on the following day - when questioned about this dramatic apparent extinction of response he answered that he just concentrated on the fact that “the situation wasn’t real”.

CONCLUSIONS

The variables which influence relapse seem to break down into two broad categories.
Firstly those interoceptive stimuli which are mediated by cognitive affective phenomena. Included in this category are the complex motivational and belief systems which characterise Marlatt and Gordon's (1985) social learning model of relapse eg anger, anxiety and apprehension.

In the second category are the exteroceptive environmental conditioned stimuli which have provided much of the substance of cue-exposure treatment paradigms such as needles, syringes and alcoholic beverages.

However, the work reviewed in this paper suggests that the cognitive/emotional factors are the most important determinants of reactions to conditioned stimuli. It is the idiosyncrasy of beliefs, fluctuating self efficacy and expectancy effects, affect and cognition, which lend a challenging variability to intrapersonal and interpersonal responses to cue-exposure.

In fact, both interoceptive and exteroceptive stimuli are significant in creating high risk situations. This combination is referred to (McLelland et al, 1986) as a “compound conditioned stimulus” in which the components are individually necessary but rarely sufficient to produce relapse. Simply stated, a potent drug or alcohol related stimulus in the presence of a particular emotional state (strongly negative or, less frequently, positive) constitutes a recipe for relapse in individuals with low self-efficacy beliefs and high expectancies for the
positive effects of the drink or drug available to them. Niaura and colleagues (1988) express this interaction thus:

“no single event, whether cognitive, affective or physiological reactions to stress or substance cues, is alone important in determining relapse; these factors interact in a complex manner to influence outcome…” (p.149).

Successful treatment approaches have attempted to combine these influence through a careful individual treatment programme based on a functional analysis of each case (Blakey and Baker 1980). Inpatient treatment avoids the danger of delayed reinforcement between sessions in the “real world”, and intensive programmes have been shown to effect within and between session habituation more effectively. McLelland et al (1986) employed 45 - 60 exposure sessions in 8-10 days.

Given that these demanding and exacting components of a cue-exposure treatment programme are observed, there is scope for employing this treatment modality. Pessimistic or equivocal results of some previous research may be due to simplistic analysis of determinants and unfounded assumptions about the relationship between cognitive/emotional and physiological events and subsequent behaviour.
Dr. John Jones, an early eighteenth century physician, in his “The Mysteries of Opium Revealed” makes the premonitory observation:

“The mischief is not really in the drug but in people”.

(cited in Orford, 1985 p.132)


PSYCH.D. PORTFOLIO

ACADEMIC SECTION

CRITICAL REVIEW NO. 3

THE USE OF METHADONE HYDROCHLORIDE IN THE TREATMENT OF DRUG DEPENDENCE
Introduction

In this essay I will briefly review the history of Methadone, its role in maintenance and detoxification, its effect on the psychotherapeutic process, and finally I will deal with attempts to appraise the therapeutic effectiveness of Methadone treatment programmes. In doing this, specific questions about the application and efficacy of Methadone treatment will be addressed.

What is it about the use of Methadone in treating opiate addiction that has attracted more comment and debate than any other treatment modality? It is probably because none of these issues have been satisfactorily settled one way or the other that the debate rages on and Methadone treatment continues to be regarded with ambivalence by practitioners and researchers in the area of addictive behaviour. Do Methadone programmes actually constitute “treatment”, or contribute to the political agenda of social control? From the clinical perspective, is Methadone treatment an adjunct or an obstacle to the more psychological processes of counselling? Since it’s first description by Dole and Nyswander in New York (Dole & Nyswander, 1967) the popularity of Methadone as a treatment strategy has waxed and waned. Hailed by some as the only realistic harm reduction strategy and condemned by others as “no longer a solution to the problem but part of the problem itself” by others, the debate continues to thrive.
Methadone - a Historical Perspective

Methadone Hydrochloride was the first effective and widely available synthetic opiate. Its development in Germany during the second world war arose out of the disrupted supply lines between Europe and the Far East (the established source of pharmaceutical Opiate, Morphine and Heroin). The urgent need for effective analgesia led to the development of Dolophine, named in honour of Adolph Hitler. This drug, later named Methadone (or Physeptone) was uncovered after the war by the American occupying forces and was later to play an important role in the search for a medical cure for drug addiction.

The use of Methadone in the treatment of addiction was pioneered by the American innovators Dole and Nyswander (1967). The authors postulated that Heroin addiction caused metabolic changes within the central nervous system, inducing a "narcotic hunger" (Shannon, 1992) and that the treatment turns Heroin addicts into constructive law abiding citizens. The early widely acclaimed success of Methadone treatment led to a swift expansion of Methadone treatment programmes in the United States, based around the city of New York. Ten years later it became an integral part of the Dutch harm reduction experiment and was introduced to Amsterdam by Dr. Wijnand Mulder, the head of the mental health department of the Amsterdam Municipal Health Service (Buning, 1992).
By the end of the 1970’s, Methadone had largely replaced Heroin (Diamorphine) as the drug of choice in drug dependency units throughout the United Kingdom. Methadone has certain properties which made it more attractive to clinic staff, even if the patients who used the clinics had just the opposite reaction! It’s long half life allowed once daily dispensing, its effects were less immediate and powerful than the Heroin which it replaced and this gave Methadone a lower street value and less prominent role in the black market. Condemned by Opiate addicts as downright boring, foul tasting and harder to withdraw from than Heroin itself, Methadone continued to flourish as a Heroin replacement (Stewart, 1987).

By the mid 1980’s the growing HIV epidemic ensured a co-ordinated public health response in which Methadone prescribing and needle and syringe exchange schemes has been pivotal. Methadone Hydrochloride is available in oral liquid form (its most common preparation), in tablet form and less often in injectable ampoules.

Although policies on the prescribing of Methadone vary considerably dependent on time and location (Senay, 1988), and while there has been considerable fluctuation in dosage (Griffiths et al, 1988) a broad and important distinction has been made between maintenance and withdrawal prescribing. The former implies therapeutic goals of stabilisation and risk reduction while the latter has abstinence as its objective.
Maintenance prescribing of opiate substitutes has continued to attract debate since it was first described by Dole and Nyswander (1967), both by prescribers and recipients. A frequent criticism is that the socialisation of opiate use by providing safe and legal supplies for the dependent individual does not constitute treatment any more than the long term prescription of Lorazepam for anxiety. Others (Edwards, 1969), have pointed out that maintenance prescribing may in fact encourage people to maintain their existing lifestyle and thus prevent them from having the compelling incentive to try to stop using opiates.

These criticisms arise out of the (not always explicit) assumption that abstinence is the only legitimate goal of treatment. The emergence of HIV and Aids has introduced the concept of harm reduction as a justifiable treatment goal. The practical implications of these two conflicting ideologies have given rise to disagreements and inconsistency in working practices. Whether an opiate user presenting for treatment is offered a non-prescribing, swift Methadone reduction or maintenance Methadone schedule may depend more on the accident of their address than their clinical assessment.

Peele (1981) observes, “the many mistaken and costly ideas about defeating addiction that have been propagated all stem from the same fundamental error. This is the failure to understand that a person is addicted to an experience. If a cure for addiction fails to take into account
a person's need for the addictive experience, he or she will simply be set
loose to seek a comparable experience elsewhere”.

This observation may give us a clue to the alarming growth in the use and
distribution of other powerful psychoactive drugs such as Cocaine and
“Crack” in places such as New York and Amsterdam, where low threshold
opiate substitute prescribing services exist. Simply stated, I am suggesting
that when an individual’s opiate habit is catered for in a way which causes
minimal fuss, aggravation and cost, that individual may be enabled to
divert their energy and resources to the acquisition of alternative
pleasurable stimulation. Senay (1988), for example, notes that “a
significant number of Methadone maintenance patients increase alcohol
consumption to the point, in some cases, where it becomes “alcoholic”
drinking”.

A variety of sources (ACMD 1982, Stimson and Oppenheimer, 1982) have
identified the low morale among staff in clinics where maintenance
prescriptions are used. The feeling was prevalent that therapeutic contact
was the price the client had to pay to obtain a prescription rather than a
vehicle of behaviour change.

The effectiveness of Methadone maintenance has also proved a
contentious issue. Wilks (1989) reviews evidence that suggests no
difference in death rates or criminal behaviour between maintenance and
non-maintenance populations. Others (Dole, 1989; Cooper, 1989) defend
the normalising effect of maintenance Methadone and suggest that failures
are not due to maintenance itself but largely to inadequate daily doses. Confusion arises, therefore, as to whether the tool itself is at fault or the modus operandi.

Care or Control

A feeling of unease is generated by the Huxley-like “brave new world” which has been ushered in by the state financed and co-ordinated chemical distribution schemes (Methadone maintenance programmes) which control and monitor the behaviour of some of the most deprived and disadvantaged members of urbanised civilisation (Drucker, 1989) Trebach (1982) speaks for many when he raises the ethical issue of the “social control” implied in Methadone maintenance. Strang (1987), somewhat euphemistically, speaks of a “social contract”. Drug treatment agencies often attach stipulations to prescribing agreements which might include proof of employment, stable accommodation, provision of urine specimens and cessation of illicit drug use. Whose ends are being served? Is the drug worker an agent of social control, or a therapist helping a confused individual to sort out his or her chaotic lifestyle?

If behavioural control is the objective there is a good argument for reintroducing more favoured and short acting injectable preparations and considering the use of stimulants in maintenance programmes as well. Such ideas (Marjot, 1987) have usually attracted fierce opposition. There is a ubiquitous methodological inconsistency in embracing maintenance programmes while resisting the very strategies which would make this
form of intervention more widely effective. However, if the drug worker is a therapist helping the individual out of the trap of dependence, the use of Methadone to attract or retain clients is collusive and ultimately sabotages the main task of treatment.

Even the achievement of social conformity as a goal of Methadone maintenance has not gone unchallenged. Foy et al (1989) followed up 50 individuals on an Australian Methadone programme. Of the 50 admissions, 35 where terminated because of drug abuse, absenteeism, violence or drug dealing. Only 8 patients achieved a stable state without other drugs over a three month period. No improvements were noted in patients relationships, social situations health or criminal activities. Hume and Gorta (1989) found that 70% of a sample of 377 prisoners on a Methadone programme were re-convicted after release.

Despite the ambiguous results and conflicting research reports, the United States persists in the use of Methadone as the anaesthetic of disaffected minorities. The City of New York has an estimated drug using population of 250,000 people. Poorer ethnic groups such as African American and Hispanics are over-represented in this number. Various treatment programmes offer approximately 40,000 treatment slots which almost without exception offer long-term Methadone maintenance. Of the estimated 500,000 narcotics addicts in the United States (most of them Heroin users) half are in the City of New York. Thus the City, with less than 4% of the nations population, has approximately 50% of its addicts.
In New York City alone, over 63,000 children are now in foster care, once again with an enormous African-American Hispanic predominance. Infant mortality among minority groups has increased by 10% since 1960, congenital syphilis has increased by 400% to 500% among non white children in New York City over the last five years (Drucker, 1990). On state run Methadone maintenance programmes, doses, attendances, levels of counselling and dispensing arrangements are all controlled by state and federal law. Decisions which in the United Kingdom would be taken on a clinical basis are preordained by legal directive or enforced by insurance cover. The vast majority of patients on Methadone maintenance programmes are covered by Medicaid, the safety net medical insurance offered by the state for those without the means to pay private insurance premiums. Medicaid, for example, will pay for a patient to receive inpatient detoxification for five days. Thus the decision to discharge on the sixth day becomes more financial than clinical. Because they are closely governed by state and federal laws, the administration of one Methadone programme seems not dis-similar from that of another. The use of illicit drugs rarely leads to the withdrawal of, or reduction in prescribed Methadone since the outcome is greater destabilisation of the individual lifestyle, a higher frequency of offending and high risk behaviour. Breaking the rules is therefore an indication that the Methadone prescription should be, if anything, increased rather than decreased. It has long been the view of advocates of Methadone maintenance that failures are due to inadequate doses and that you can
increase prescription levels to a point where infringements no longer occur. Nevertheless, an indeterminate number of clients of Methadone maintenance programmes regularly use Cocaine and/or Crack Cocaine. At the Beth Israel Clinic in New York (Personal Correspondence, Zanko 1988) the figure of 43% is used for public relation purposes but a more honest opinion indicated that a figure of 90% was more realistic, a statistic which validates the remarks of Peele cited above.

The Dutch experiment introduced the concept of low threshold Methadone programmes. As in the United States, traditional therapies have been abandoned and Methadone maintenance has become no longer a means to an end, but an end in itself. The Department of Health in the Netherlands has defended its policies on the basis of laissez-faire social pragmatism. Buning (1992) enumerates the positive effects of this harm reduction approach “the situation in Amsterdam is relatively quiet as compared to the early 1980’s. The average age of drug users keeps on increasing; the percentage of young drug users is decreasing; we have not seen an explosion of Aids cases amongst drug users; the estimated number of drug users is slightly declining; there are no indications for a new wave of drug users; and neighbourhoods are scarcely complaining about the nuisance of drug users”. On the negative side, the effective dismantling of the opiate black market has led to an ever expanding stimulant market in Cocaine, Ampethamine and Ecstasy. At present there are no plans to provide these drugs on prescription. A second unwanted side effect of the liberal Methadone policies has been the major influx of drug users from
other countries. To date, 25% of the 6,000 Amsterdam drug users originate from other European Countries such as Italy, Spain, and Germany.

Methadone as an Adjunct to Treatment - the pursuit of abstinence

The use of decreasing doses of Methadone to help clients achieve the goal of opiate abstinence has, if anything, attracted more criticism than the drugs use in maintenance programmes.

Clients themselves complain that withdrawal from Methadone is more difficult than from Heroin (Stewart, 1987). Other reviews have found Methadone withdrawal programmes less effective than in-patient regimes and no more effective than the spontaneous remission rate. (Brewer, 1988).

Murphy and Irwin (1992) describe Methadone treatment as “living with a dirty secret”. A ten year study of male and female addicts identified Methadone treatment as a marginal identity, neither conventional nor junkie. Methadone patients occupied a limbo state between two different worlds, lost in a social gap between conformity and addiction.

Most importantly, the addition of a Methadone prescription to the climate and context of an individual’s decision making can radically alter the process of change and the sustained motivation which empowers progress. The urgency of the desire for active change which marks the client’s initial
presentation, can be weakened by the prescribing of Methadone and at worst can lead to premature exit (Prochaska and Di Clemente, 1984) and return to a pre-contemplative stage in the cycle of change.

Stimson and Oppenheimer (1982) report on the observations of one drug dependency unit in which staff felt that while the use of Methadone "...alleviates the immediate problem of obtaining drugs, it reduces that motivation and energy needed to change the individual’s situation and he frequently resumes illegal drug use in addition to his prescription after a period of some months...".

The situation is made even more complicated when the different and conflicting strategies of maintenance and detoxification are combined in one treatment service. Henk Ten Have and Paul Sporken (1985) in a paper which deals with the ethics and philosophy of medical approaches to Heroin addiction write, "the aim of treatment may be defined as either to achieve abstinence from Heroin use or to neutralise the social consequences of such use. In fact, treatment tries to achieve both". Strang, (1987) attempts to make a distinction between flexibility of treatment services and liability to manipulation. He attempts to side-step the all important question of the power struggle which can ensue between client and therapist. He writes, "It is not just a matter of handing the patient a shopping list of all the available treatments: rather it is a matter of advising them on the much smaller list of potentially appropriate
options...". Just how coercive is the advice? Who chooses which options are eliminated from the supermarket shelf and which remain available?

Local opiate-using communities have swift and effective channels of communication (Fraser and George, 1988). It would be naive to expect that the treatment contract negotiated with John Smith on Tuesday morning has no bearing on the expectations of Mary Jones presenting on Wednesday afternoon. The problem with the shop window approach, stated bluntly, lies in the expectations and assumptions that it generates.

The laudable intent of harm minimisation has implications which are antagonistic to the therapeutic goal of abstinence for therapist and client alike.

There is no doubt that out-patient Methadone detoxification programmes have a significantly poorer outcome than similar in-patient programmes (Gossop et al, 1986). Too often, doctors who set out to prescribe Methadone reduction programmes end up providing maintenance by default. Planned reductions are postponed and often abandoned. Client preference for stabilisation has made the rapid out-patient detox using Methadone (Guide-lines on Good Clinical Practice 1984 HMSO) virtually mythical.

From the psychological stand point, a crucial issue has still to be addressed; what is the effect of Methadone prescribing on the counselling or psychotherapeutic endeavours which may be offered in addition (or even as a condition of) the prescription. It is paradoxical that the very
strategy which is widely acknowledged to attract opiate users into treatment services and retain them longer in treatment (Strang and Stimson, 1990; Rosenbach and Hunot, 1994) may obstruct the psychotherapeutic endeavours aimed at shifting the client away from dependent behaviours and confirm a lifestyle and behaviour pattern centred on “chemical coping strategies”.

If, as I have suggested above, Methadone acts as an emotional anaesthetic which removes the impetus to change it is logical to predict that it will be antagonistic to non chemical therapeutic endeavour. Yates (1993) in a characteristically forthright article writes;

“Many researchers have noted a wide spread tendency for drug users to mature out of addiction in their late twenties. If in years to come this process appears to have been significantly undermined, then we will know. We will know that a policy which took the dangerous street-wise runts, neutered them, and left them at home on the sofa with a bottle of Methadone and pap television for company, have indeed condemned many - who might otherwise of stopped - to a life on drugs. Maybe society will feel this is a price worth paying for reducing the Aids threat and the number of videos nicked from urban households. But I don’t think they’ve been asked and we don’t have the right to take this decision without them. Even if society did approve, don’t expect me to like it. It’s not why I started in this business, and I wouldn’t find it a good reason to continue” (p.16).
In essence, two imposing forces are in operation; psychotherapy seeks to help people move through the process of change while the addition of a Methadone prescription reduces discomfort, and alleviates the negative aspects of drug dependency.

Others, however, do not see Methadone and psychotherapy as mutually exclusive. Woody et al (1986) conducted a research study on psychotherapy as an adjunct to Methadone treatment. They compared drug counselling (a largely clerical monitoring function) with a second group receiving supportive expressive therapy (helping the patient identify and work through problematic relationship themes, diminished denial and encourage expression) and a third group who received cognitive behavioural therapy (uncovering and understanding the relationship and influence of automatic thoughts and underlying assumptions on problematic feelings and behaviours). All three groups received Methadone prescriptions. The results suggested that patients receiving the additional psychotherapy showed more and greater gains than those receiving drug counselling alone and with less use of prescribed and self-administered medications. Woody and his colleagues also found that there were significant therapist effects - in other words some therapist are better at engaging and influencing clients regardless of the therapeutic strategy employed. Finally, and unsurprisingly, patients with concurrent psychiatric morbidity faired significantly better in the supportive/expressive and cognitively behavioural groups than in the group which received basic drug counselling alone.
Eklund and Melin (1994) interviewed subjects in a Swedish Methadone treatment programme. Comparison between those who detoxified successfully and those who failed in the attempt to detoxify indicated that the first group achieved a higher quality of life and a more stable life situation compared with the second group. While this research is flawed by the two groups being effectively self-selected, the relative poverty of the Methadone life-style is identified. The drug-free state may therefore stand as an optimum goal for therapeutic intervention.

The evidence would seem to suggest that while Methadone may inhibit the psychotherapeutic process, it does not block it altogether. It might be seen by case hardened addiction therapists as the price one has to pay to ensure attendance. No therapy whatsoever can be offered to a client who fails to attend.

The Therapeutic Appraisal of Methadone

Methadone’s status as a treatment strategy depends entirely on the perspective from which it is viewed. Critics who insist upon abstinence as the only legitimate treatment goal remain unmoved by evidence by Methadone’s benefits, arguing that it is unacceptable even when it is successful because it perpetuates dependence on an opiate drug - Methadone itself. Even those who view Methadone from the public health (harm reduction) stand point in which society rather than the individual becomes the client point out that its use leads to a reduction rather than a
cessation of high risk injecting behaviour, HIV transmission, illicit drug use and criminality. Hall (1993) condemns this “perfectionism” by pointing out that other treatment strategies such as psychotherapy or residential treatment are not measured by such a stringent yard stick. Harm reduction, he points out, means just that. It does not mean harm elimination. Because of methodological difficulties, he argues, we need to settle for evidence from comparative observational studies because randomised controlled trials are not feasible and are ethically questionable. Since the available evidence fails to establish scientific certainties, the debate rumbles back and forth. In the USA, Ball and Ross (1991) in their influential study of a number of Methadone programmes concluded that those which use higher doses of Methadone and provide adequate medical ancillary services, produced greater reductions in illicit opiate use, hence reducing criminality and high risk drug use. Gottheil et al (1993) monitored the use of other drugs in a large (229) cohort of patients in Methadone Treatment. They concluded that there was a significant decrease in illicit opiate use as a function of the length of enrolment time. Notably (see above) they did not see a decrease in cocaine use over the same time period. However, in a review article on Methadone treatment in Australia, Shannon (1992) concludes “the current expansion of Methadone treatment is not based on a solid foundation of empirical evidence. Australian programmes are being expanded for emotional rather than logical reasons and the current Aids issue is effectively being promoted as a rationale for this expansion. It would appear that there is
no conclusive evidence at present to suggest that Methadone is uniquely useful in reducing the spread of HIV to any significant degree”. (Page 96).

Conclusion

The use of Methadone in combating opiate dependence is complicated by both ideological and practical conflicts. There is a confusion between the treatment model and the social control model, which is further complicated by the antagonistic implications of abstinence and harm reduction as treatment goals. It has been used variously as a strategy for reducing acquisition crime (shoplifting, burglary, car theft etc), as a strategy for breaking the black-market in illegal drugs, as a strategy to entice and retain drug users in treatment programmes, as a strategy to provide relatively painless detoxification, as an exercise in social control and most recently as a public health strategy to reduce the spread of HIV infection in intravenous drug users. Methadone's performance in achieving these various targets is far from uniform. Bodies as well respected as the World Health Organisation have concluded that Methadone maintenance is cost effective and saves lives. However, given the dramatic increase in the number of clients on Methadone in the last five years, one might ask whether Heroin addicts may not be regarded as losers in this large scale experiment in social control and behaviour modification. Since it seems to be patients with long-standing opiate misuse who enter Methadone treatment, some might have become drug free or reduced consumption if treatment was not available. Similarly, if Methadone treatment was not
available, some would probably have converted for HIV, Hepatitis B or Hepatitis C. Others would be serving prison sentences for acquisitional crime and others would have died as a result of overdose, infection or violence.

Porter and Ghodse (1994) argue succinctly that while “Methadone maintenance was more effective than a control in retaining people in treatment and reducing opiate use and the rate of incarceration in prison .... it implies that opiate dependence as an intractable condition with no hope cure. The motivation to change and withdraw from opiates is a dynamic process that can be facilitated by the therapist: widespread adoption of maintenance treatment might render these skills obsolete and deter the patient from attempting abstinence” (p.83).

The answer to the question “Is Methadone treatment successful”? depends largely on the operational definition of success and the endeavour undertaken.

It would be naive, punitive and possibly dangerous to advocate abandoning the use of Methadone on the basis of the difficulties which this paper attempts to identify. However, all treatment modalities achieve their maximum effectiveness only when their limitations are fully examined and understood. The conflicting agendas and ideologies that surround opiate substitute prescribing ensure that the debate will continue.


Elkund, C., Melin, L. et al Detoxification from Methadone Maintenance Treatment in Sweden *International Journal of the Addictions* 29, 5 pp627-645


PSYCH.D. PORTFOLIO

CLINICAL SECTION

MEDICATION OR MANIPULATION:

GENERAL PRACTITIONERS' INVOLVEMENT

IN AND ATTITUDE TO TREATING ADDICTION PROBLEMS
Introduction

The treatment of substance misuse relies heavily on individual counselling sessions with users on an out-patient basis. The effectiveness of this form of treatment, combined with the increase in demand has led to radical changes in current and future service delivery. It is now recognised that a wide field of non-specialists will become involved in the treatment of substance misuse. Probably the most influential generic group involved in identifying and responding to substance misuse is the general practitioner and other members of Health Centre based primary health care teams.

In this section of the portfolio I will attempt to address the involvement of general practitioners in a number of ways. I will review the current literature on addiction treatment in general practice, document the attitudinal survey conducted in Worthing to estimate local levels of willingness to participate in combined treatment programmes with specialist support (shared care), include the components of a training package developed for local use with GP’s and finally include the rationale, and job description for the development of a Primary Care Liaison Post in substance misuse.

The components of this section combine to form the framework of a strategic approach aimed at increasing the current level of involvement by GP’s in treatment of substance misusers. This consists of a summary of the literature on GP attitudes, an ad hoc baseline measure of current local willingness to become involved, a training intervention to increase
knowledge and confidence in addressing substance misuse in general practice and the development of a specialist post supporting Primary Health Care staff to encourage involvement and increase participation in the treatment of substance misusers in the general practice setting.

LITERATURE REVIEW

General practitioners have long been exhorted to involve themselves in the management of patients with drug problems. The DHSS guidelines on good clinical practice in the treatment of drug misuse (1984) states as its first recommendation:

“All doctors have a responsibility to provide care for both the general health needs of drug misusers and their drug related problems”.

Seven years later the D.O.H. guidelines on clinical management of drug misuse and dependence are even more specific:

“All doctors have a responsibility to provide care for both the general health needs of drug misusers and their drug related problems”.

“Every doctor should address the health needs of his patients who misuse drugs, including straightforward treatments for drug dependence such as Methadone withdrawal from opioids...”.

While the treatment of drug misusers has important implications for the individual, in the light of HIV/AIDS, the wider implications for the whole community need to be considered. It appears likely that one of the main routes by which HIV infection will spread to the general heterosexual
population will be through sexually active injecting drug users. (Ronald, Witcomb, Robertson et al, 1992). It follows that efforts to halt the spread of HIV depend in large measure on persuading drug misusers to adopt safer injecting and sexual behaviour, an area in which general practitioners are seen to play an important role. The influential report by the Advisory Council on the Misuse of Drugs (1988) is specific in its advice:

"the advent of HIV makes it essential that all GP’s should provide care and advice for drug misusing patients to help move them away from behaviour which may result in them acquiring and spreading the virus". (page 76).

The problem of drug dependency is both large and geographically widespread throughout the United Kingdom. General practitioners, because they are accessible and can be approached without stigma, are uniquely well placed to intervene not just with problem drug users but with non-problem (ie new and recreational) drug users who may otherwise have no contact with treatment services. (Cohen and Schamroth, 1990, Glanz and Taylor, 1986).

This role is, however, hampered by the relative paucity of informed and practical advice to general practitioners. In the introduction to their excellent handbook on drug misuse for general practitioners, Banks and Waller (1988) lament that "for once a preface is not apologising for adding one more book to an overcrowded scene. The field is sadly empty. Here is a start".
It has long been established that policy and practice are largely determined by attitude (see for example Strang and Stimson, 1990). The authors point out that “...our views on drug problems reflect and shape the reality they address. They have major consequences for policy and resource allocation, and real impacts on the people we are dealing with - people who use drugs”.

**Attitudes to Substance Misusers**

Unfortunately for the drug taker, there is a wealth of research data hammering nail after nail into the coffin of the Doctor-addict relationship. Drug addicts have been described as “dangerous, sexually unattractive and psychopathic” by hospital staff (Romney and Bynner, 1972). The authors point out that the way hospital staff often react to addicts may well be important in deciding whether the addict agrees to remain in hospital and finish his treatment. Bewley (1975) recommends that general practitioners have a high index of suspicion when dealing with drug abusing patients, pointing out that “...some degree of deception of the GP by the patient was almost always clear”.

More recent research has proved just as pessimistic. McKeganey (1988) reports the affective terminology used by general practitioners describing aspects of their work with Opiate abusing patients. Words like “unrewarding” “difficult” “exhausting” “threatened” “angry” “cynical” “depressed” “pressured” and “saddened” were repeatedly stressed. Abed
and Neir-Munoz (1990) reported questionnaire data received from a sample of 203 general practitioners. Most of them agreed that drug addicts were unreliable, that the problems the addicts experienced were of their own making and that they did not consider drug addiction to be a medical problem. Neville et al (1988) studies 36 heroin users attending general practices in Dundee. The authors comment that “the heroin users... had a noticeable history of dishonest and violent behaviour towards medical staff”. McKeganey and Boddy (1988) report on a sample of 23 general practitioners working in 5 Glasgow Health centres. Many of the doctors reported that drug abusing patients were manipulative in their relationships, that they were adept liars and that they were rarely motivated to give up their drug taking. The doctors in the study felt threatened by the level of pharmacological knowledge possessed by the patients and found that their expectations of patient behaviour were challenged by the assertive demands which characterised the consultations with opiate abusers. One GP in the study described a consultation with an opiate abuser as “…him saying what he wants and me saying I’m not prepared to give him them”. The authors stress that the lack of established individual or practice policies in dealing with drug addiction enables and even encourages manipulation by patients. They recommend that strategies be developed which maintain at least some continuity in the care of these patients.

Chang (1987) presents a more humanistic argument. She concludes an article recommending family involvement and attending narcotic
anonymous meetings by reflecting “I’m sure that most contacts between addicts and general practitioners are of value to the addict. They are also of value to the doctor as they teach us to like these seemingly unloveable people, to see some good in most of them and, above all, not to sit in judgement”.

Crowther and her colleagues (1977) reflect that the attitude among medical professionals towards drug abusers is similar to their attitude towards the drugs themselves. This theme, considered in combination with the disproportionately high rate of drug and alcohol problems among medical practitioners (Brooke et al 1991, 1993) provokes the challenging hypothesis that doctors are reluctant to deal with drug users because of their own ambivalence towards the drugs abused by the patient. Crowther et al (1977) suggest that both the physician role and the high level of access to drugs is at least a potential contributor to the high rate of addiction amongst doctors and to their perception of opiates as “the most dangerous of all the drugs” (ranked in her study). In dynamic terms it might be suggested that doctors negative attitude toward addicts reflects their projected fears of personal addiction.

Slightly more hopeful are the results of Bells study (Bell et al, 1990) in which over three quarters of a sample of 206 inner London general practitioners were prepared to offer narcotic misusing patients supportive interviews. Few however were willing to prescribe for them. Roche (1991) and her colleagues conducted an attitudinal survey amongst 34
general practitioners working around Sydney and New South Wales in Australia. Attitudes varied from the predominantly positive (for minor tranquillisers) to the sympathetic (alcohol problems). Opiate users, by contrast, were least favoured with hostility expressed by most towards them.

Telfer et al (1990) has conducted one of the few surveys which explores the battlefield from the patient's perspective. The clients in this study, although describing GP consultations as easy to obtain and confidential, considered that their GP's were lacking in knowledge and understanding and were critical and unsympathetic. It would appear that the patients anxiety and ambivalence about the consultation may be as great as the doctors. Sheehan and her colleagues (Sheehan et al 1986) examines a sample of 50 drug users seeking professional help. The most common fears expressed were “disappointing those trying to help” (58%), “not being offered treatment needed” (48%) and “worried about being seen as one of life's failures” (36%).

The accumulated data would therefore suggest that the prejudice, apprehensions and negative attitudes held by both the drug misusing patients and the doctors militate against the usefulness of contact in general practice and have negative implications for therapeutic outcome.

Management Strategies in General Practice

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Cohen and Schamroth (1990) developed a 12 stage management strategy from their experience of treating 85 opiate addicts over a 12 month period in a central London practice. This is replicated in a further section of this paper which details a training input for GP’s. Although it has obvious limitations (adhering to a 3-8 week detox, demanding a hand written life history without explanation), this planned strategic approach is welcome in providing a check-list to assist doctors in the logical, predictable and co-ordinated treatment of drug dependency, in an area where few practical guidelines exist.

Cohen and Schamroth’s conclusions at the end of the twelve month study period are vague but optimistic. According to the “best information available” (p318) twenty two percent of the study sample were “off all illicit drugs” and a similar percentage had found gainful employment. Other outcome measures, the authors report, “were more difficult to quantify” but they introduced a note of pious hope that high risk behaviour, diet, hygiene and criminal activity were all improved by having a clear management strategy.

This study reflects the underlying assumption that having a protocol may be sufficient rather than merely necessary. The means become the end and little if any rigorous attempt is made to demonstrate the effectiveness or otherwise of a particular policy, protocol or regime.
Wilson et al (1994) offer advice on appropriate dosages of Methadone from their experience of two practices in Glasgow, one offering lower dose treatment, the other employing higher doses and showing greater and more sustained improvement.

Coleman (1988) offers guidance on the assessment of needles - sharing risk (see GP training input) which takes the form of a sensible check-list with suggested solutions.

Banks and Waller (1983) offer practical hints to GP’s which have lost none of their applicability over the passage of a decade. They suggest (pp 172-173) that GP’s find out about all local sources of assistance for substance related problems before being confronted by a demanding patient in the surgery. Once again the importance of a coherent and accepted corporate policy within the practice is stressed. GP’s should, the authors suggest, decide how much time they can set aside to the treatment of substance misuse cases and develop an appropriate case-load based on this realistic audit:

“Half a dozen drug takers a year treated on these lines will keep you busy but it will be a tremendous contribution to the Country’s drug problem”.

The authors go on to offer a useful assessment framework in seven sections:
Assessment

1) Is there a medical problem at all?
2) Are there concurrent social, financial or emotional problems?
3) What kind of drugs/alcohol are being used and by what route?
4) What previous treatment has been offered and what was the outcome?
5) Patients reasons for seeking treatment and their expectations of that treatment?
6) What are the significant elements of the patients background/family history?
7) What support network is available to the patient?

Banks and Waller (1983) do not, however, consider the pragmatic question of prioritisation. Addiction problems are relatively costly and very time consuming. This presents a real dilemma for the hard pressed general practitioner who has a dozen competing priorities presenting daily at the surgery door. In this context, a consideration of attitudes towards addiction, and their role in prioritisation is essential. It is to these attitudinal issues that Ann Roche turned her attention.

Roche and her colleagues (1991) divided a sample of Australian GP’s into a “provisional typology” which had implications for their style of management of drug/alcohol problems:
**Interactive problem solvers** are most sympathetic, incorporating counselling, have realistic treatment goals and view addicts as not dissimilar to other patients.

**Traditionalist Healers** see their role primarily in disease related issues. While they have listening skills they are more likely to fear, resent, or be frustrated by the "self-inflicted injuries" of drug and alcohol addiction.

**Expert technologists** are primarily concerned with physical sequelae of illness and see their expertise in the clinical management of disease rather than in management of the whole person.

Unsurprisingly the authors associate the first group with more successful engagement and treatment of substance misusers. The second and third categories of doctors tend to blame, reject or confront addicted patients and impose unrealistic goals on them, thereby setting them up to fail. This, in turn, strengthens the pessimistic self-fulfilling prophecy of failure with which the practitioner approaches this group of patients. The study contains implications for training of doctors at both undergraduate and post-graduate levels.

**Costs and benefits in the treatment of addiction in the primary care setting**
A number of authors have turned their attention recently to the costs (in terms of time and money) of providing treatment for drug misusers in the primary care setting.

Cohen and Schamroth (1990) conduct a persuasive cost-benefit analysis of illicit opiate use. They estimate that the average (0.5g) daily heroin habit required the theft of £70,000 worth of goods annually per patient. In contrast, the total cost of methadone maintenance is £663 per year including consultation time of 15 minutes every fortnight.

Wilson et al (1994) came up with a more comprehensive (and expensive) package for methadone treatment with counselling support and regular toxicology costing £2030 per year - still far below the cost to society of illicit drug use.

Ronald, Witcomb et al (1992) studies 432 problematic drug users in an Edinburgh general practice totalling 11,200 patients. The “average” patient consulted a doctor 4.4 times per year (the national average is 4.7). In contrast, the patients with drug related problems consulted a doctor 19.5 times per year. The drug users who were HIV positive, however, contacted a doctor on average 24.9 times per year.

Several authors (Wilson et al, 1994, Ronald et al, 1992) identify the opportunity for general health screening and intervention over and above the management of the dependence problem. In their study, Wilson et al
(1994) comment on the neglected state of their sample’s health; cervical cytology, Hepatitis B and C screening and testing for HIV and TB had all been widely ignored until attending to the drug problem had retained the patients in general practice for a significant length of time. Patients engaged in this form of treatment, suggest Cohen and Schamroth (1990) are less at risk of HIV infection, septicaemia, abscesses, deep vein thrombosis, and hepatitis. Amenorrhoea and weight loss is less frequent in women once engaged on a treatment programme.

Alcohol and Smoking

Although this paper concentrates on the management of narcotic addiction in general practice, a far greater body of published research has investigated the effect of brief intervention by GP’s in the treatment (or discouragement) of problematic smoking, and alcohol consumption. Although a detailed analysis of these areas lies outside the scope of this paper, they should be included here, albeit briefly, both for the sake of completeness and also to identify the partial overlap of techniques and skills necessary in all areas of substance dependency.

Typical of the genre of brief intervention smoking treatment is the work of Sanders et al (1993). 751 patients received a brief nurse-administered anti-smoking intervention in general practice (advice, information on health risks, offer of treatment by nicotine replacement and tests of fitness, peak
flow lung capacity etc). 135 subjects reported stopping smoking, of whom
44 (5.8%) reported sustained cessation for at least one year.

Hajek (1990) estimated that up to 8% of all smoking patients would give
up following a 5 minute intervention by their general practitioner. If all
GP’s did this with all smokers, the average practitioner would persuade 48
smokers to stop each year. His argument, of course, overlooks the flaw
that marginal smokers would stop first and confirmed smokers would
continue to smoke - thus high annual returns in cessation could not be
sustained.

By far the greatest attention has been paid to the treatment of alcohol
problems in general practice. Saunders et al conducted of multi-country
comparative study (1993) of 1,888 primary health care patients. 18%
demonstrated “hazardous and harmful alcohol use” and 23% had
experienced at least one alcohol related problem in the previous year.
Buchsbaum et al (1991) found alcohol dependence in 12% of a general
studied 400 general practice patients aged over 16 in the UK and found
16% were high or intermediate risk drinkers.

Finally a note on the popular “early detection” instruments used, and their
limitations. Rydon et al (1992) compared pick-up rates on the CAGE (a
popular 4 item screening test for alcohol problems), the Short Michigan
Alcohol Screening Test (SMAST) and the judgement of primary care
physicians in 371 general practice patients aged between 18-65yrs. The CAGE classified 11.4% as having alcohol problems, the SMAST 23.9% and the doctors judgements identified 7%. The comparison validity between instruments was very tenuous; the doctors failed to identify 65% of the CAGE - identified problems and 82.3% of the SMAST - identified problems. The implication is that questionnaire reliability is far superior to clinical intuition which both under-estimates and fails to diagnose the early stages of drinking problems. (Both the CAGE and the SMAST are included in the training input section).

Various studies have shown that brief counselling (Health advice, cost-benefit analysis, physiological measures of damage and improvement) has a positive effect on drinking behaviour compared with waiting list control groups. (Romelsjo et al 1989, Horrath 1993).
Conclusions

Up to 2% of adults in general practice may inject opiates (Wilson et al 1994). A larger percentage (undetermined) may have problems with other illicit drugs. Between 11% and 24% may have problems related to the consumption of alcohol. Extrapolated to the average general practice case-load this represents a significant source of morbidity. Early and brief interventions have been shown to be successful with a small but significant number of smokers and drinkers. Interventions with narcotic addicts are more time and resource consuming but have been shown to be cost effective. The major problems to be overcome are 1) the predominantly negative attitude of general practitioners to substance misusing patients (especially illicit drug users) and 2) the cost implications in terms of time and personnel. The adoption of a “shared care” philosophy with counsellors based either in the primary team or in local secondary services appears to be a workable compromise. There is a balance to be struck between making help readily available to those who need it while maintaining appropriate vigilance to avoid abuse of the service to the detriment of other service users without substance related problems.

The issue of negative attitudes presenting a challenge to shared care policies should not be under-estimated. Stimson (in Strang and Stimson, Eds, 1990) writes:
“...our views on drug problems reflect and shape the reality they address. They have major consequences for policy and resource allocation, and real impacts on the people we are dealing with - people who use drugs...” (p122).

Drug misusers and addicts often challenge Doctor's expectations of the patient role. They can be demanding. Their knowledge of specific areas of pharmacology, prescribing, dosages etc upsets the long established assumptions inherent in the doctor-patient relationship. Substance misuse can be an unrewarding condition to treat in terms of social reinforcement and sometimes does little to support or enhance the status of the doctor.

All these problems may account for the predominantly gloomy accounts of addiction treatment in general practice and the cautious attitude of practitioners who face this challenge.
GP's ATTITUDES TO SUBSTANCE MISUSERS IN WORTHING
A QUESTIONNAIRE SURVEY

Introduction

Little is known about whether the availability of local specialist services makes general practitioners more or less willing to take on opiate misusing patients. Similarly, the correlation between positive or negative attitudes to substance misuse and willingness to undertake treatment is not clear from the literature review. The question of whether or not general practitioners are prepared to treat opiate misusers can be examined more closely and more usefully by determining what range of services they are or are not prepared to provide. This paper attempts to examine these questions using a representative sample of general practitioners within a district health authority which also provides the catchment boundaries for a statutory community substance misuse team serving a population of approximately 250,000.

Method

A self administered questionnaire was filled in by 36 general practitioners who attended a lecture on the role of the general practitioner in the treatment of drug addiction, at the Post Graduate Medical Centre in Worthing, West Sussex. These lectures are part of the rolling weekly programme of post graduate education for local practitioners. To of the 90 minute slots each year deal with aspects of addiction treatment.
Attendance at these training session is voluntary but the general practitioners who attend could claim a fee.

The participants in the survey were self selected and the fact of their presence at the lecture indicated an existing interest and possibly a positive bias towards treating drug misusers. In an attempt to remove any bias the survey was extended by sending the same questionnaire to 36 general practitioners within the district who did not attend the lecture. There was no attempt to match samples for demographic variables. The 36 lecture attenders were excluded. Postal subjects were selected to represent a geographical spread across the district. Senior partners were selected from each practice not represented at the lecture. 152 GP’s work in Worthing. The combined sample (n = 65) represents 42% of all practising GP’s in the catchment area of Worthing Health District. 29 (81%) of the general practitioners replied to the postal survey. The two surveys were first analysed separately to check for significant differences between the lecture sample and the postal sample. Then the surveys were combined giving a sample size of 65. The questionnaire examined attitudes towards addiction and addicts, especially intravenous drug users (IVDU’s), various modalities of Methadone prescribing, treatment goals and harm reduction strategies. A subsequent section canvassed individual and practice policies on accepting patients with a known history of drug addiction. The questionnaire went on to examine changes in attitude to drug use as a result of the spread of AIDS and HIV. Finally they were asked to
comment on how the working co-operation between general practice and community substance misuse teams could be maximised.

The questionnaire (see tables 1 and 2) was developed by the author as a specific tool to canvass local opinion. The individual items in the questionnaire draw on local experience of numerous case discussions with general practitioners who have voiced their concerns and reservations about treating addiction. The questionnaire also draws on the conclusions and recommendations of the successive Advisory Council on the Misuse of Drugs (ACMD) reports (1988, 1989, 1993). In these reports the increasing importance of the role of general practitioners in the identification, assessment and treatment of drug misusers is stressed although the implications on attitudes and working practices is not addressed.

An ad hoc research tool was used. Given the limitations and the local nature of this piece of work, no attempt was made to assess the reliability or validity of the questionnaire items or responses. The conclusions are presented in percentages and offer an indication of local GP interest and involvement in treating substance misusers.
Results

Initially the responses were examined for differences between those completed at the lecture (N = 36) and those completed through the random postal survey (N = 29). Whilst there was some variability in responding, no clear trend emerged which differentiated the two groups. It therefore seemed appropriate to combine the two samples (N = 65), and consider the data en bloc.

However, a few minor details of interest did arise. The GPs attending the lecture (see table 2) were more likely to be aware of injecting drug users on their list than the postal survey sample, with averages of 4 per doctor and 2 respectively. One might speculate that those attending the lecture were there because they perceived drug addiction to be a larger problem in their general practice than their colleagues who did not attend.

The second discrepancy which arose from visual inspection of the data was the greater likelihood of the lecture attenders to agree that AIDS was more dangerous than drug misuse itself (88% of the lecture sample compared with 57% of the postal survey sample). It is possible that this increased awareness of the threat to public health posed by HIV also influenced the decision to attend the lecture.

The combined data from the attitudinal survey present a more hopeful picture than much of the work reviewed in the introduction section.

Whilst it is clear that the ubiquitous distrust of drug using patients by
general practitioners obtained in this sample, there is a wide spread willingness (see table 1) to engage in the chemical management of opiate dependency by using Methadone.

The majority of GPs felt that intravenous drug users presented a threat in general practice and would exploit doctors given the chance. However, more disagreed with the statement “addiction is largely a self-inflicted injury and a waste of NHS resources”, (40%) than those who agreed (23%). 37% neither agreed or disagreed. Attitudes towards the use of Methadone in general practice (table 1, questions 4-8), showed, not surprisingly, that oral preparations were more acceptable than injectable and that detoxification programmes were more acceptable than long term maintenance programmes. Even so, one third of the sample (34%) found long term prescribing acceptable. The balance of opinion (table 1, question 8) was towards the use of Methadone only by specialised drug dependency units. It should be noted that the districts from which the sample was drawn has no access to DDU facilities. For the last six years, local opiate addicts have relied on general practice for the chemical treatment of their dependency. On the validity of abstinence as a goal of treatment (question 9) more GPs agreed that treatment should aim at abstinence than disagreed. The results, however, showed a degree of ambivalence. Questions 10, 11 and 12 (table 1) were intended to draw on GPs attitudes to harm reduction. Results show that these are overwhelmingly positive. Only a small minority disagreed with harm reduction practices, needle and syringe exchanges or the training of
<table>
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<th>ATTITUDES OF GENERAL PRACTITIONERS TO TREATING DRUG USERS</th>
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<tr>
<td></td>
<td>Strongly agree</td>
<td>Agree</td>
</tr>
<tr>
<td>1.</td>
<td>IVDU’s present a threat in general practice</td>
<td>16</td>
</tr>
<tr>
<td>2.</td>
<td>IVDU’s exploit doctors, given the chance</td>
<td>35</td>
</tr>
<tr>
<td>3.</td>
<td>Addiction is largely a self-inflicted injury and a waste of NHS resources</td>
<td>5</td>
</tr>
<tr>
<td>4.</td>
<td>GP’s should prescribe Methadone only in oral form</td>
<td>14</td>
</tr>
<tr>
<td>5.</td>
<td>GP’s should prescribe Methadone in oral and injectable form</td>
<td>0</td>
</tr>
<tr>
<td>6.</td>
<td>GP’s should prescribe Methadone in detoxification programmes</td>
<td>12</td>
</tr>
<tr>
<td>7.</td>
<td>GP’s should prescribe Methadone in long term maintenance programmes</td>
<td>1</td>
</tr>
<tr>
<td>8.</td>
<td>Methadone should only be prescribed in specialist clinics such as drug dependency units</td>
<td>17</td>
</tr>
<tr>
<td>9.</td>
<td>Drug treatment should always aim at abstinence</td>
<td>12</td>
</tr>
<tr>
<td>10.</td>
<td>Harm reduction is a legitimate goal of treatment</td>
<td>21</td>
</tr>
<tr>
<td>11.</td>
<td>Needle/syringe exchange schemes are a good idea</td>
<td>38</td>
</tr>
<tr>
<td>12.</td>
<td>IVDU’s should be taught to inject safely by</td>
<td>23</td>
</tr>
</tbody>
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intravenous drug users in safe injecting techniques. Finding out to what extent doctors would become involved in these measures themselves was not within the scope of this paper.

Table 2 deals with awareness of drug using patients, practice policies and the interface between HIV infection and willingness to treat opiate addiction. Approximately half the sample were aware of injecting drug users on their lists. The number of known users ranged from 1-10, with a mean of 3. Surprisingly, most of the GPs would accept someone with a known history of drug addiction as a permanent patient (79%) or as a temporary patient (30%). Only a fifth (21%) of the sample would not accept them. Although lack of established and accepted policies facilitates manipulation by opiate using clients (McKeganey and Boddy, 1988), two thirds of the survey sample had no common policy on the acceptance of new patients or treatment of existing patients with drug related problems. This proportion includes those respondents who were uncertain whether or not they had a common policy!

Although the vast majority (73%) agreed that the spread of AIDS posed a greater threat to individual and public health than drug misusers, only half the sample (51%) admitted to having altered their attitude to treating drug addiction as a result of this awareness. There is obviously a conceptual gap which weakens the public health argument that drug addicts in treatment are a lower personal and public health risk than those outside treatment.
<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Uncertain</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Are you aware of any injecting drug users on your list</td>
<td>yes</td>
<td>44</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If yes, please give approximate number</td>
<td>range 1-10</td>
<td>mean 3*</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Would you accept someone with a known history of drug addiction?</td>
<td>a) as a permanent/temporary patient</td>
<td>79</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>b) not accept them?</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Does your practice have a common policy on the acceptance of new patients with drug-related problems?</td>
<td>yes</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>no</td>
<td>49</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>uncertain</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Does your practice have a common policy on the treatment of existing patients for drug-related problems?</td>
<td>yes</td>
<td>34</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>no</td>
<td>48</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>uncertain</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Do you agree that the spread of AIDS is a greater danger to individual and public health than drug misuse (ACMD Report 1989 p.17)</td>
<td>yes</td>
<td>73*</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>no</td>
<td>11*</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>uncertain</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Has your attitude to the treatment of drugs addiction been altered by the spread of HIV through intravenous drug use?</td>
<td>yes</td>
<td>51</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>no</td>
<td>45</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>uncertain</td>
<td>4</td>
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* see text for discussion of differences between sub sample responses.
Finally, the questionnaire invited a brief comment on ways in which working co-operation between general practice and community drug teams could be maximised. Some of these comments are reported in the discussion section.

Conclusion

This paper has covered a review of the literature addressing the treatment of substance misuse and addiction in general practice. A distinction is made between the predominantly negative attitudes which obtain and the variable willingness to participate in treatment. A further distinction is noted between general practitioners being "left to get on with it" and their involvement in programmes of shared care in collaboration with specialist addiction services. Notwithstanding the ad hoc nature of the questionnaire used in this study, the results have some validity within the geographical context of Worthing in West Sussex. Personal relationships, regular contact and support from a local addiction service with a good reputation appear to have some impact in overcoming the negative attitude of GP’s to substance misusers. This local ad hoc research indicates a wide spread willingness among GP’s to participate to some extent in programmes of shared care.

The high rate of response to the postal survey (81%) would seem to indicate a high level of concern among GPs about their role in the treatment of drug misuse. It appears that problem drug users cause something of a dilemma for GPs. On the one hand they are faced with a
patient group which they find difficult, unrewarding, a waste of time and at worst threatening and manipulating. On the other hand they are under pressure by local and national advisory bodies to become involved. In spite of their reservations, a large majority of the general practitioners in our survey were prepared to accept patients with a history of drug addiction and many were prepared to engage in active treatment using a drug such as Methadone. Some however were careful to point out in the comments section of the questionnaire that they were only prepared to treat these patients for health problems unrelated to their drug misuse.

GPs, it seems, are faced with opportunities which are at once difficult and challenging. They are well placed to intervene early in cases of drug misuse and are often the first (and only) statutory agency approached by the drug taker. It is clear, however, from this sample that whilst they have much sympathy with harm reduction arguments, few see it as their role to intervene in this area. Furthermore, the degree to which general practitioners become involved in treating drug misusers depends on the level, availability and accessibility of alternative specialist services. Given easy access to a local DDU (Drug Dependency Unit) for example, (Bell et al, 1990) most GPs would prefer to refer to a specialist facility. The GPs in our survey had no access to DDU facilities. Although a surprising high percentage of GPs were willing to treat drug misusers, it was often under duress, or because of the lack of alternatives. There was also a broad agreement that the closer the contact between the general practitioner and the community drug team, the more favourable the perceived outcome and
the greater the likelihood of both doctor and patient satisfaction. Lack of training, expertise and factual knowledge about drug related problems were also given by several as barriers to a harmonious therapeutic relationship. Some GPs, especially those in single handed practices or working without a coherent practice policy, felt isolated. "I'm on my own trying to treat them. I don't know what other people are doing".

Sympathetic and impartial contact between general practitioners and drug misusing patients may be enough to influence some to adopt lower risk drug related and sexual behaviour. Some may even be prompted to reduce or give up altogether. For others, the availability of Methadone (in stable or reducing doses) may provide a period of stability. At the very least it keeps a patient in contact, offering a continuing opportunity to influence the drug taker towards abstinence or the intermediate goals of harm reduction as well as general health care. A prescription of Methadone which is conditional on attendance at a local community drug team offers the opportunity to involve a specialist multi-disciplinary agency and to draw on their expertise to share the undoubted burden these patients represent. One way or another, we must all learn to live with drugs (Gossop, 1982) and while we still have problem drug takers and general practitioners the former will continue to approach the latter for assistance. Some of the attitudinal and practical disadvantages which undermine the potential usefulness of these contacts are discussed in this paper with implications for changes of policy and attitude both at individual and practice level.


Hajek, P. (1990) *The role of minimal intervention in smoking cessation* Presentation at the Maudsley Hospital.


TRAINING SESSIONS FOR
GENERAL PRACTITIONERS
INTRODUCTION

To encourage general practitioners to become involved in the treatment of addiction a training input was delivered through lecture slots on the post graduate medical training programme as well as on the vocational training scheme for GP trainees. The content, lecture plan and handouts of this programme are included. Participant evaluation of the programme content and presentation is included at the end of this section.

Aims of 1½ hr training session

- To raise the profile of drug problems and their treatment.
- To increase participants knowledge of local treatment facilities.
- To encourage shared care.
- To increase basic knowledge of assessment and intervention strategies.
- To encourage the development of practice policies on the treatment of substance misuse in primary care.
TRAINING SESSION FORMAT

- An introduction to the Options service for people with Drug or Alcohol related problems - setting the scene in Worthing.

- Screening methods - examples of questionnaires and rating scales.

- Stages of change.

- Levels of intervention.

- Realistic goals and achievable targets.

- When to refer to specialist agencies.

- Developing a practice policy.

- Questions and discussion.
BRIEF LECTURE NOTES

• INTRODUCTION

Following this 90 minute training session it is intended that a number of aims will be achieved and that participants will experience a higher level of confidence and competence in dealing with substance misuse issues in general practice. As general practitioners, this audience will be only too aware of the increasing demands made by growing numbers of individuals with problems relating to drug or alcohol use, misuse, and abuse. The specific areas which I propose to address are as follows:

• RAISING THE PROFILE OF DRUG PROBLEMS AND THEIR TREATMENT

Substance misuse encompasses both drug and alcohol problems. Historically, however, the stigma attached to drug dependency has been far greater than that attached to the problematic use of alcohol. Part of this stigma arises from the illegality of drug use and part from the lack of familiarity with illicit substances. Therefore, increasing the level of knowledge about drugs, drug problems and their treatment and making the obvious comparisons between the management of drug and alcohol problems in general practice will have the effect of desensitising
doctors, reducing uncertainty by the introduction of clarity and measurement, and empowering them to respond in a considered and effective way to both drug and alcohol related issues in general practice.

- **INCREASE PARTICIPANTS KNOWLEDGE OF LOCAL TREATMENT FACILITIES**

In this talk I will cover briefly the most important features of the Options community drug and alcohol service including:

- Statement of Role
- Statement of orientation
- Statement of function
- Catchment area
- Staffing levels
- Estimated potential demand
- Profile of treatment episodes

- **ENCOURAGING SHARED CARE**

‘Shared care’ implies the joint management of individual clients by two or more agencies. In this context the agencies involved would be the community drug and alcohol team and the primary health care team. There are no rigid rules governing the division of responsibility in shared care but a reasonable scenario may be as follows:
Drug and alcohol problems are often first identified in primary care either reported by the patient or identified by the practice staff. Identification should be followed by discussion, assessment, exploration of realistic goals and, if necessary, an appropriate referral to involve specialist drug and alcohol services. Specialist services have greater access to psychotherapeutic skills, specific expertise in the management of substance misuse problems, experience in appropriate referral to inpatient detoxification services and residential rehabilitation services. Specialist services can also provide focused group therapy programmes such as anxiety management, anger release and relapse prevention. Throughout the programme a high level of collaboration and communication is necessary between all agencies involved in the shared care process.

- **INCREASING BASIC KNOWLEDGE OF ASSESSMENT AND INTERVENTION STRATEGIES**

In this presentation I will briefly illustrate the cycle of change proposed by Prochaska and DiClemente (1982). This tool enables clinicians to estimate current levels of motivation and suggests appropriate motivational interviewing techniques for clients presenting at different stages of readiness for change.

In addition I will be giving examples of various assessment tools.
- General Substance Use Screening Questionnaire for wider general practice list surveys to establish levels of pathology and prioritise target groups for intervention

- The Brief Michigan Alcohol Screening Test (Brief MAST)

- The CAGE questionnaire to detect alcohol dependence in general population samples

- Hepatitis risk from unsafe sex or unsafe injecting practice

- Assessment of injecting behaviour, risk estimation and suggested solutions

- The short opiate withdrawal scale (adapted from Gossop M: Drug Dependence Clinical Treatment Unit, Bethlem Royal and Maudsley Hospital UK). This self rating scale of common opiate withdrawal symptoms allows inter-subject and intra-subject comparison and can be used both as to assess priority for treatment such as substitute prescribing as well as monitoring response to ongoing treatment for opiate dependency.
• ENCOURAGING THE DEVELOPMENT OF PRACTICE POLICIES ON THE TREATMENT OF SUBSTANCE MISUSERS IN PRIMARY CARE

Having established that the treatment of substance misuse falls within the remit of general practice and that tools and techniques exist to introduce clarity and objectivity into the undertaking, it is imperative to develop policies on the treatment of substance misusers which are both owned and adhered to by all practice staff including general practitioners, clinic nurses, health visitors, receptionists etc. In this presentation some clear guidelines on does and don’ts in practice policies are given which may be useful in the development of treatment policies in individual practices.

AN INTRODUCTION TO THE OPTIONS SERVICE FOR PEOPLE WITH DRUG OR ALCOHOL RELATED PROBLEMS - SETTING THE SCENE IN WORTHING

Options have existed in Worthing since 1986. It is a multi-professional team comprising integrated drug and alcohol services under the same roof (see fig 1).
FIGURE 1

**STAFFING**

**DRUG SERVICES**

- Options Director (Substance Misuse Team)
- Clinical Psychologist
- Probation Officer
- Consultant Psychiatrist
- Administrator
- Clerical Support
- Clinical Nurse Specialist
- Drug Worker
- Social Worker
- Clinical Assistants (2)
- Prescribing Clinics

**ALCOHOL SERVICES**

- Options Director (Substance Misuse Team)
- Clinical Psychologist
- Probation Officer
- Consultant Psychiatrist
- Administrator
- Clerical Support
- Clinical Nurse Specialist
- Community Psychiatric Nurse
- Social Worker (April 95)
- S.A.A.S.
- Voluntary Counsellors
STATEMENT OF ROLE

The Options service exists primarily to provide or access information, advice and treatment for people encountering significant problems in relation to alcohol or drug use.

STATEMENT OF ORIENTATION

The Options service adopts a multi-disciplinary model of assessment and intervention. The addictive or problematic use of substances is regarded as a learned behaviour - usually arising out of a dysfunctional solution to perceived personal, social or physical problems.

Our approach is non-judgemental and respects each client as an unique individual deserving access to treatment equal to any other member of society.

The treatment offered should be free, non-discriminatory and confidential within the boundaries of professional, legal and ethical constraints.
STATEMENT OF FUNCTION

The Options service comprises a community alcohol team (CAT) and a community drug team (CDT) with partially integrated staffing allocation. The service operates mainly from a district base offering satellite clinics within the catchment area. An open referral policy ensures low threshold entry to treatment. Treatment is offered on an individual, couple, family or group basis by trained professional staff. There is a commitment to post-qualification training in relevant skills to ensure the quality of therapeutic work. The service liaises closely with other agencies in the statutory, voluntary and private sector to ensure co-ordinated and collaborative provision for care for clients using the service.

The service offers a training consultancy and research role in addition to the primary clinical role.
The catchment area is that of the Worthing District Health Authority with a population of 248,000 people. The major conurbation is Worthing where the Options centre is based. Satellite clinics operate along the coast to the west at Littlehampton (Pepperville House, Community Mental Health Team) and to the east in Shoreham (Glebelands Mental Health Day centre). North of the Downs, the service embraces Pulborough, Storrington, Steyning and Henfield. The majority of the clients are seen either at the centre in Worthing or at satellite clinics. Local contact can be arranged at convenient health centres, or domiciliary visits can be offered subject to health and safety policy.

Population analysis reveals an older than average population with between 53 and 61% aged between 16 and 64 years (Borough by Borough analysis). The average population within this age group for England and Wales was 62.9% in 1989. (See fig 2).

Figs 3 and 4 show the expected rates for problematic alcohol consumption and expected rates for problematic drug consumption respectively.

The potential size of the combined drug and alcohol problem makes it impossible for a specialist team to address the
problems of this client group in isolation. Employing shared
care and devolved responsibility at appropriate levels of
intervention ensures the provision of service to the greatest
number across the District.

The annual report of the Regional drug and alcohol team (fig 5)
shows the number of episodes of treatment reported to the
substance use database broken down by main substance used
and includes the number of episodes of injecting drug use. The
diagram shows that alcohol is by far the most frequent single
substance presenting to the service, that half the primary heroin
users have a history of intravenous use while a small percentage
of amphetamine users have a history of injecting.
WORTHING HEALTH DISTRICT 1989 POPULATION ANALYSIS

PERCENTAGE OF POPULATION AGED 16 – 64

Legend

- 53 to 55%
- 55 to 58%
- 58 to 61% in England and Wales
  - 62.9% in 1989

SOURCE: WSCC 1989 BASED "BEST ESTIMATE" PROJECTIONS

WORTHING BOROUGH
FIG 3 EXPECTED RATES OF PROBLEMATIC ALCOHOL CONSUMPTION

<table>
<thead>
<tr>
<th></th>
<th>22-35 units of alcohol per week adult males</th>
<th>22-35 units of alcohol per week adult females</th>
<th>36-50 units of alcohol per week adult males</th>
<th>36-50 units of alcohol per week adult females</th>
<th>51+ units of alcohol per week adult males</th>
<th>51+ units of alcohol per week adult females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mid-Downs</td>
<td>14,400</td>
<td>8,200</td>
<td>7,500</td>
<td>2,300</td>
<td>7,500</td>
<td>2,300</td>
</tr>
<tr>
<td>Worthing</td>
<td>11,900</td>
<td>7,700</td>
<td>6,400</td>
<td>2,200</td>
<td>6,400</td>
<td>2,200</td>
</tr>
<tr>
<td>Chichester</td>
<td>8,800</td>
<td>5,600</td>
<td>4,800</td>
<td>1,600</td>
<td>4,800</td>
<td>1,600</td>
</tr>
</tbody>
</table>

Annual Alcohol attributable deaths in West Sussex are: Mid-Downs 100; Worthing 130; Chichester 90. The higher rates per 1,000 population in Worthing reflect the older population structure with more deaths from stroke and pneumonia and alcohol attributable cancers. (Based on the Weekly Epidemiological Record 1990, 65, 297-301, See Appendix 4).
FIG 4 EXPECTED RATES OF PROBLEMATIC DRUG CONSUMPTION

The Size of the Problem

Mortality

Notifiable drugs of addiction have a relatively high mortality rate. Home Office statistical bulletin 1990 gives a 0.7% rate of deaths per year. On a case-load of 300 people, between 2 and 3 deaths per year would be expected.

Prevalence

<table>
<thead>
<tr>
<th>National</th>
<th>Extrapolated District estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis 29% 15-24 year olds</td>
<td>8,120</td>
</tr>
<tr>
<td>LSD 10%</td>
<td>2,800</td>
</tr>
<tr>
<td>Ecstasy 7%</td>
<td>1,960</td>
</tr>
<tr>
<td>Opiates 3 per 1,000 adult pop</td>
<td>594</td>
</tr>
<tr>
<td>Amphetamine 0 pr 1,000 adult pop</td>
<td>1,980</td>
</tr>
<tr>
<td>Solvents (long term) 1%</td>
<td>280</td>
</tr>
</tbody>
</table>
Number of episodes reported to the Substance Use Database by main drug used/injected (N=211)

![Graph showing drug use trends](image)

Figure 3.11.2.2

Worthing

1 April 1993 to 31 March 1994
SCREENING METHODS - EXAMPLES OF QUESTIONNAIRES AND RATING SCALES

- Fig 6 Substance use screening questionnaire
- Fig 7 The Brief Michigan Alcohol Screening Test
- Fig 8 The CAGE questionnaire
- Fig 9 Assessment questionnaire for Hepatitis B risk
- Fig 10 Assessment of injecting behaviour questionnaire
- Fig 11 The short opiate withdrawal scale
### Substance Use Screening Questionnaire

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>D.O.B.</td>
</tr>
<tr>
<td>Date:</td>
<td></td>
</tr>
<tr>
<td>1. Do you smoke?</td>
<td>Yes / No</td>
</tr>
<tr>
<td>2. How much do you smoke? (per day)</td>
<td>______</td>
</tr>
<tr>
<td>3. How long have you smoked?</td>
<td>______</td>
</tr>
</tbody>
</table>

*All smokers should receive further assessment and advice.*

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Do you drink alcohol?</td>
<td>Yes / No</td>
</tr>
<tr>
<td>5. In an average week, how much alcohol do you drink?</td>
<td></td>
</tr>
</tbody>
</table>

*If greater than 21 units (male) or 14 units (female) a more detailed assessment of the patients drinking is necessary.*

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Do you use any pills, medicines, drugs or tablets other than those prescribed for medical reasons?</td>
<td>Yes / No</td>
</tr>
<tr>
<td>E.g. to help you:</td>
<td></td>
</tr>
<tr>
<td>- relax, sleep, cope with stress</td>
<td></td>
</tr>
<tr>
<td>- feel good</td>
<td></td>
</tr>
<tr>
<td>- have fun or for excitement</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Do you ever need to use more of your medicine than prescribed?</td>
<td>Yes / No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Do you regularly use non prescription medicines from the chemist?</td>
<td>Yes / No</td>
</tr>
</tbody>
</table>

*A positive response to any of the above questions should be followed up with a more lengthy assessment of the patient's drug use.*

Further advice and information may be obtained from.
<table>
<thead>
<tr>
<th>QUESTIONS</th>
<th>YES</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever been arrested for drinking or driving after drinking?</td>
<td>Yes</td>
<td>9</td>
</tr>
<tr>
<td>Have you ever been in a hospital because of drinking?</td>
<td>Yes</td>
<td>8</td>
</tr>
<tr>
<td>Have you ever gone to anyone for help about your drinking?</td>
<td>Yes</td>
<td>7</td>
</tr>
<tr>
<td>Have you ever had delirium tremens (DTs), severe shakiness, heard voices or more days in a row because you were drinking?</td>
<td>Yes</td>
<td>6</td>
</tr>
<tr>
<td>Have you ever neglected your obligations, your family, or your work for two or more of the above because of drinking?</td>
<td>Yes</td>
<td>5</td>
</tr>
<tr>
<td>Have you ever gotten into trouble at work because of drinking?</td>
<td>Yes</td>
<td>4</td>
</tr>
<tr>
<td>Have you ever lost friends or girlfriends/boyfriends because of drinking?</td>
<td>Yes</td>
<td>3</td>
</tr>
<tr>
<td>Have you ever attended a meeting of Alcoholics Anonymous (AA)?</td>
<td>Yes</td>
<td>2</td>
</tr>
<tr>
<td>Do friends or relatives think you are a normal drinker?</td>
<td>Yes</td>
<td>1</td>
</tr>
</tbody>
</table>

TABLE 3

The Brief MAST

The Brief MAST, the range of scores selected question MAST, the range of scores selected equally well between alcoholics and the bottom portion, dealing with the lower forms of the MAST was higher than the Brief MAST, dealing with the 25-question MAST, the Brief MAST.
Alcohol dependence is likely if the patient gives two or more positive answers.

1. Have you ever felt you should Cut down on your drinking?
2. Have people Annoyed you by criticising your drinking?
3. Have you ever felt bad or Guilty about your drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (Eye-opener)?

encephalopathy, rib fractures, subdural haematoma, pneumonia, arrhythmias and alcoholic cardiomyopathy, subacute pontine myelinolysis, and Zieve’s syndrome.

THE ALCOHOL WITHDRAWAL SYNDROME

Some patients are not troubled by withdrawal symptoms, but others have a very unpleasant withdrawal and a few develop a life-threatening disturbance. The risk does not depend on intake: some heavy drinkers are not physically dependent and suffer little physiological disturbance when they stop drinking.6

Withdrawal symptoms start around 3-6 hours after stopping drinking, and usually last 5-7 days, occasionally longer. Early symptoms (up to 12 hours after the last drink) include tremor, sweating, anorexia, nausea, insomnia and anxiety.
Are you at risk?
A guide to assessing your risk of hepatitis B

To assess your risk, answer all of the questions on this page. Then check your score on the panel overleaf.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you had more than three sex partners in the last twelve months?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Do you think there is a real chance that you may have more than two or three sex partners in the next twelve months?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Do you ever have sex without using a condom outside of a stable relationship?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Have you ever had a sexually transmitted disease?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Do you think there is a chance that you may have a ‘holiday romance’ this year?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Has your current sex partner suffered from hepatitis B?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Do you think that one of your past sex partners could have had hepatitis B?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you inject drugs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Does your partner inject drugs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Has your partner or a close member of your family ever had hepatitis B?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Are you a gay man?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Would you describe yourself as a sex worker?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you come into contact with used needles and syringes while at work?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Do you come into contact with blood or other body fluids while at work?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Do you ever travel to developing countries – particularly Africa and the Middle East for more than three months at a time?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Is your job one of the ones listed below?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Dental hygienist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Drug dependency unit staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Mental health/psychiatric unit staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Mortician/mortuary technician</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Embalmer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Laboratory worker/technician</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Hospital porter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Hospital cleaner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Police officer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Fire officer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Ambulance crew member</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Prison officer</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Questions

#### Reduction of harm
- When did you last share needles?
- How do you clean your needles/equipment?
- If you share, do you use someone else's needle or do you pass your needle on to them?
- How many people do you share with?
- Where do you obtain the needles?
- What injection sites do you use?

#### Meaning of needle sharing behaviour to the patient
- Do most people in your group share their needles in the same way?
- Is there pressure from others to change/stay the same?
- Do you share with someone close to you?
- Who taught you to inject?
- Did someone first inject you?
- Does this sometimes still occur? Who is person?
- How much comfort do you get from just pricking yourself with the needle, heating up your heroin, seeing blood in the syringe?
- Do you take drugs alone or in a group?

### Suggested solutions

- Explain risks of sharing
- Suggest they avoid cold water rinsing and use mild bleach solution, boiling
- Suggest they clean them well
- Suggest they reduce the number
- Provide list of needle exchanges or friendly chemists
- Suggest they avoid the femoral vein particularly
- Suggest strategies to resist pressure
- Ask whether they are going to change
- Suggest the patient avoids them, or see both together for counselling
- Consider joint meeting
- Tackle one behaviour at a time
- Consider need for other social outlet

---

Figure 1. Assessment of injecting behaviour.
FIGURE 11

Amended 16.10.92

THE SHORT OPIATE WITHDRAWAL SCALE

<table>
<thead>
<tr>
<th>NAME:</th>
<th>DATE:</th>
</tr>
</thead>
</table>

Please put a tick in the appropriate box if you have suffered from any of the following conditions in the last 24 hours.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Nil</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling sick</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stomach Cramps</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muscle Spasms/Twitching</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feelings of Coldness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Pounding</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muscular Tension</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aches and Pains</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yawning</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Runny Eyes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restlessness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insomnia/Problems Sleeping</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CYCLE OF CHANGE

AFTER PROCHASKA & DI CLEMENTE,
1982
STAGES OF CHANGE

The work of Prochaska and DiClement provides a framework within which to assess readiness for change and motivational state in individuals presenting for treatment. The process of motivational interviewing enables us to help individuals move towards active change through affirmation, empowerment, raising levels of cognitive dissonance and assistance in conducting a cost benefit analysis of behaviours and consequences.

In fig 12 a diagrammatic representation of the cycle of change illustrates the cycle through which individuals move in the process of modifying attitudes and behaviours. The duration of the stages may vary but it is suggested that the sequence does not.

- People who have not yet entered the cycle of change are called ‘pre-contemplators’ and are characterised by lack of awareness of a need for change. They may however seek change in other people’s responses to their behaviour (deflection of responsibility).
- The first stage of changing behaviour is the ‘contemplation stage’ in which people see their behaviour as problematic and begin to think about changing it.
• At some point a decision to change follows contemplation of change. Often a specific life event (arrest, illness, break-up of relationship etc.) will provide the catalyst for change.

• The next stage is the ‘action stage’ were the problem behaviour is changed, control over substance misuse is established either through abstinence or reduction of harmful levels of intake.

• Following action comes the ‘maintenance stage’ where people consolidate behaviour change.

• If maintenance is successful people exit the cycle to a dependence free life. If it is unsuccessful they move into the ‘relapse stage’ and most commonly begin the cycle again. The model implies that relapse is a learning behaviour enabling individuals through experience of relapse triggers to better manage and maintain behavioural change on the subsequent cycle. Relapse experiences therefore ultimately increase the chance of sustained change rather than confirming the negative believe that change is impossible.
HIERARCHY OF INTERVENTION

Residential Rehabilitation

Inpatient Detoxification

Maintenance Prescribing

Outpatient Detoxification

Counselling

Reassurance

Advice

Information
LEVELS OF INTERVENTION

Fig 13 presents a hierarchy of intervention from the basic provision of information and advice to costly and labour intensive interventions such as inpatient detoxification and rehabilitation at the Apex. This hierarchy can be viewed as pyramidal in that a larger number of individuals will require the lower levels of intervention and progressively fewer will require the more complex and specialist interventions.

It is appropriate for general practitioners and other generic workers to develop confidence, communication skills and a sufficient database to provide information, advice and reassurance to individuals presenting with straightforward requests for help arising out of experimental and recreational use of substances.

Counselling can be provided in a number of settings depending on the complexity of the case, the skills of the counsellor available and the goals of intervention. Practice nurses or primary health care based community psychiatric nurses may adopt a counselling role for substance misusers or refer onto specialist counsellors, psychology department or specialist substance misuse teams. Brief intervention strategies have been shown to be successful and effective and compare well in terms
of outcome and cost effectiveness to longer term psychotherapeutic intervention. Counsellors should develop policies which ensure that they operate within their level of competence and make appropriate referrals to other agencies when necessary.

Outpatient detoxification can be delivered by primary health care teams in most cases. Some complex cases (see indications for referral onto a specialist service, Fig 14) will require the expertise of a multi-disciplinary specialist service. Alcohol detoxification can usually be conducted over a 10 day period while narcotic detoxification can take considerably longer. This difference is slightly paradoxical since the complications of alcohol detoxification are mainly physical while those of narcotics detoxification are mainly psycho-social.

Maintenance prescribing should initially be handled by a specialist service and once a significant level of stability has been reached that prescribing contract can be handed over to a general practitioner with regular monitoring and support provided by a keyworker placed either within the primary health care team or the specialist substance misuse service.

Inpatient detoxification is always the role of a specialist service. The Worthing District has access to regional beds at Springfield
Hospital in Tooting via the regional drug and alcohol team at St. George's Hospital.

Residential rehabilitation is available in a number of different locations around the Country. Rehabilitation can be accessed through community care funding by the local authority and specialist advice should always be sought to ensure the best match of client and treatment programme in terms of length, treatment style, philosophy and geographical location.
FIGURE 14

INDICATIONS FOR REFERRAL ON TO A SPECIALIST SERVICE

- Dependent on several drugs simultaneously.

- History of multiple failed treatment attempts.

- Co-existing serious physical or mental illness (e.g., HIV disease, Hepatitis).

- Physically or verbally aggressive.

- Shows little or no sign of stabilisation on standard substitute drugs.

- Poor progress in detoxification programme.

- Probably required inpatient treatment for detoxification or rehabilitation.

REALISTIC GOALS AND ACHIEVABLE TARGETS

In tackling substance misuse it should not always be assumed that abstinence is the only legitimate goal of intervention. There are a number of intermediate goals which may be both valid and achievable. These include

- **Personal gains** - the client demonstrates greater control over his/her life. A reduction in physical and mental symptoms which might be attributed to the problematic use of drugs or alcohol.

- **Interpersonal gains** - The client demonstrates an ability to establish and maintain improved relationships, demonstrates greater assertiveness in being able to achieve interpersonal goals without causing offence, or the client demonstrates a decrease in aggressive or submissive behaviour.

- **Social gains** - The client demonstrates an improvement in social functioning, for example stable or improved housing conditions, employment status, a reduction in criminality, more involvement in the organisation of the local community, or more appropriate and constructive past times and activities.

- **Harm reduction gains** - The client demonstrates a reduction in the number, type, or frequency of high risk activities which could be detrimental to his or her physical well-being or that of others.
SPECIFIC GOALS RELATED TO HARM REDUCTION

One of the most common causes for the failure of treatment programmes is that unrealistic targets have been set either by the client or the therapist or both. In some cases abstinence is incorrectly assumed to be the objective. Sometimes even when abstinence is correctly identified the time-scale is inappropriate and the pace of behaviour change too swift. For many problem drug and alcohol users intermediate goals are appropriate either as stepping stones towards the end point of abstinence or as an end point in treatment themselves. Examples of intermediate goals are:

- Reduction/cessation in sharing injecting equipment
- Reduction/cessation of injecting drug use
- Move from more to less harmful substances (heroin to methadone, spirits to low alcohol beers)
- Establishment of a legitimate prescription to reduce criminal activity
- Reduction in overall drug/alcohol use
- Containment of harmful use within less dangerous settings (for example leaving the car at home when intoxicated or using injectable drugs privately rather than in a “shooting gallery”)

156
• Maintaining therapeutic contact with a treatment agency to monitor ongoing problems

• Ensuring adequate access to and use of primary health care medical facilities.

Just as abstinence should not always be assumed as the treatment aim, it should not be assumed that an individual presenting “for treatment” is ready or willing to change their drug or alcohol related behaviour. Many contacts or referrals arise out of external coercion in ‘pre-contemplative’ individuals.

The work of William Miller on ‘Motivational Interviewing’ would suggest that the appropriate intervention in these cases is to conduct a thorough and balanced cost-benefit analysis of positives and negatives arising out of drug/alcohol use. This will:

• provide information on possible risks

• inform decision making

• raise “cognitive dissonance” (this is the psychological discomfort which arises out of conflicting beliefs and behaviours).

• restore to the individual the responsibility for change rather than impose on them the necessity for change.

• defuse the individuals expectation of a hostile, critical and judgemental reception.
In this way, Miller suggests, the individual can be helped through the process of cognitive change from 'pre-contemplative' to 'contemplative' - a point at which more active and directive treatment interventions can be considered.
DEVELOPING A PRACTICE POLICY

Surprisingly few practices have established written policies on the treatment of substance misuse. For some practices that do have a policy, it is simply not to accept patients who admit to dependency problems onto the practice list and to discharge those patients already on the practice list who are discovered subsequently to have a dependence problem. While this policy has the merit of simplicity it fails to recognise the principle of clinical management of drug misuse and dependence (HMSO 1991). In this policy statement from the Department of Health, every Doctor is encouraged to address the general health needs of his patients who misuse drugs, including straightforward treatments for drug dependence such as methadone withdrawal from opiates. Additionally, refusal to treat this client group places an unequal and excessive burden on specialist services and general practitioners who are prepared to take on substance misusers. A caseload which would not be too onerous shared among many agencies becomes unmanageable when shared between only a few.

It is therefore the intention of this presentation to encourage every general practitioner and every primary health care team to take on a “fair share” of local individuals who present with dependence problems and to do so effectively by developing
clear policies for the management of appropriate patients, the roles and responsibilities of shared care treatment programmes and the level at which referral onto a specialist agency becomes necessary. Towards this end, I have developed a list of “rules of thumb” which may help to shape and inform a practice policy. Over and above these general principles will exist local considerations pertaining to individual practitioners and practices. This list provides a framework within which to construct and develop a policy appropriate to each individual practice or health centre.
Practice Policy - Some do’s and don’ts

1) Employ the three C’s at all times. These are:

Communication - make sure that any treatment programme, prescribing regime, contract, level of prescription etc. is clearly written in the patients notes and communicated through regular practice meetings. Patients are not always seen by the same Doctor and therefore notes should always be referred to before any action is taken. This avoids duplication, misunderstanding and inconsistency of response.

Clarity - be clear about the information, advice and treatment given to patients. State unambiguously what treatment you are prepared to offer them and (just as important) what treatment you are not prepared to offer them. Be prepared to explain your reasons for both. Be clear about practice policy. Be clear about what you will expect of the patient and what the patient can expect of you.

Consistency - once a plan has been developed, stick to it. Make sure, through the process of communication and clarity, that your partners stick to it as well. Obviously, in any treatment programme, there should be room for some reasonable flexibility but the boundaries within which this flexibility is permitted should also be clearly and consistently stated.

The relationship between general practitioners and individuals with drug dependency problems often breaks down. Most frequently the reason for this deterioration in the therapeutic relationship arises out of a lack of communication, clarity and consistently.

2) Attempt to provide a non-judgmental and holistic approach to the patient. Once they have been taken on to your practice list ensure that all their physical problems are dealt with and any appropriate investigations undertaken rather than focusing entirely on their drug problems. Referral onto other specialist agencies such as Housing, Social Services, or Social Security may also be part of this holistic approach to their management.
3) Respond to requests of assistance with an appropriate degree of priority but do not be rushed into ill judged decisions which are difficult to reverse. It is always reasonable to defer making important decisions for a day or two to allow you to consult a colleague or specialist team. You should always reserve the right to do so.

4) Assessment should always precede treatment. Do not do anything until you know what you are going to do and why you are going to do it. Find out all the necessary information before reaching a decision.

5) Do not prescribe injectable preparations unless there are extraordinary reasons for doing so. This would usually be done by, or at the advice of, a consultant psychiatrist specialising in the field of addiction.

6) Do not prescribe psycho-stimulants unless there are extraordinary reasons for doing so as outlined in 5 above.

7) Ensure that the boundaries of confidentiality which you can offer the patient are clearly understood (i.e. notification of social services where there are child care issues, registration with the Home Office in the case of notifiable drugs, communication with the FHSA etc).

8) Ensure at all times the security of practice staff and property. It is unwise to work alone in the building and care should be taken to ensure the security of practice note-paper, prescription pads, drug samples etc.

9) Do not replace drugs once they have been dispensed whatever the reason. If you make this boundary clear from the outset and stick to it, the number of requests for replacement prescriptions will drop dramatically.

10) Impress on your patients the importance of attending the surgery sober. This is both for their own safety and that of other people attending or working at the surgery. It is also worth pointing out the potentially dangerous interaction between many prescribed drugs and alcohol. Finally, to attempt to counsel an intoxicated individual is inevitably a vain endeavour. They will take in little and retain even less.
11) Treat patients with dependency problems with the same respect with which you would wish them to treat you. In this way you enable them to regain some of the dignity which they may have lost.

12) Become familiar with all the local specialist agencies to which patients with dependency problems can be referred including non-statutory, self-help groups, day centres, housing departments, citizens advice etc. The treatment of patients with dependency problems should never be a lone pursuit.
USEFUL AND ACCESSIBLE REFERENCE TEXTS

• British National Formulary (updated editions always available to General Practitioners) - see the section “Controlled Drugs and Drug Dependence” under “guidance on prescribing.


• “Guidelines of good Clinical Practice in the Treatment of Drug Misuse” Report of the Medical working group on Drug Dependence. DHSS: London 1984 - of historical interest mainly. Serves as an interesting comparison to (2) above.

WORTHING POSTGRADUATE MEDICAL CENTRE

EVALUATION OF PGEA MEETING

Title: Substance Misuse in General Practice

Speaker: Mr. Michael George  Date: 9th May 1995

Content/Subject:

Please **CIRCLE** one number on each line as you feel appropriate

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<td>Nothing New</td>
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3) Is there any aspect of the topic, not covered today, that you would have found useful.

4) Any other comments:

Thank you for your help
Results of Evaluation Forms

Total no. Attenders: 31
Total no. General Practitioners: 23
Total no. Completed Evaluation Forms: 16

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No other comments on Evaluation Forms
PROPOSAL FOR PRIMARY CARE LIAISON POST IN SUBSTANCE MISUSE

Introduction

The literature review has identified the poor relationship which can exist between doctors and their substance misusing patients. Feedback from local general practitioners suggests two interventions which may facilitate positive change. Firstly, increasing the level of knowledge of drug misuse and effective interventions for general practitioners and primary health care staff may serve to increase confidence, competence and positive expectancy. Secondly, the introduction of specialist workers into primary care settings to support the delivery of care and to involve generic workers in the assessment and treatment of substance misuse may serve to promote the role of primary health care staff in the treatment of addiction.

This section documents the rationale underpinning the development of such a post and follows the attempt to recruit funding and support for this undertaking. It includes suggestions for implementation, audit markers and a job description.

Background

The initial impetus to develop a liaison worker post came from various different sources. One was a representation from various disciplines involved in the Worthing Advisory Group on Substance Misuse (WAGOSM). The issue was also raised by members of the steering group on Alcohol Services who are responsible for the West Sussex Review of Mental Health Services for people with alcohol problems. This document became part of the District and Countywide purchasing strategy for substance misuse services in West Sussex.
The initial proposal was for a liaison worker for people with alcohol problems the rationale behind the development of this post was as follows:

Worthing District Health Authority has a high number of individuals drinking in excess of safe limits. About 6,400 males and 2,200 females are likely to be drinking in excess of 51 units of alcohol weekly and are therefore classed as very heavy drinkers. A substantial proportion of these drinkers will come into contact with other services as a result, direct or indirect, of their drinking behaviour. These agencies include general practice and other primary health care workers, police, probation, general hospitals, social services and accommodation agencies. The level of liaison between these organisations and the alcohol team is poor. This is because there are not enough alcohol workers to respond effectively to requests for information, advice or assistance from other agencies nor can the alcohol team work pro-actively in setting up policies and practices for the integration of case management between all the agencies who are likely to be involved with a heavy drinker. Additionally, inadequate training in dealing with alcohol related problems leaves a lot of generic workers feeling unskilled and lacking in confidence. This in turn reduces the likelihood of identification of problem drinking in the first place and, when identified, a high likelihood of immediate possibly inappropriate referral onto a specialist service.

It is a well rehearsed argument that there will never be enough specialist alcohol workers in any District Health Authority to address effectively a potential case-load of 8,500 people. A liaison worker would therefore be proactive in their involvement with other agencies, helping them to correctly identify drinking problems and appropriately
manage them on a consultancy basis, referring onto specialist services only when this was the most appropriate course of action.

The post might have developed in the following way:

A full-time, well qualified member of staff (nursing Grade G, CQSW or equivalent) would be employed to forge links initially with staff on local general hospital wards, custody sergeants in local police stations, accommodation officers, general practitioners and practice nurses. The liaison worker would then develop strategies to enable generic professionals to conduct brief assessments such as the cage or mast to identify problem drinkers. Next they would help target organisations to develop brief intervention skills, giving appropriate advice on the physical harms associated with chronic heavy drinking and information about self-help strategies to cut-down on their drinking and access to local agencies. The liaison worker would also act as a filter for appropriate referrals to the specialist team when necessary and as co-worker and consultant whenever specialist referral on was deemed unnecessary. In this way individuals within other non-specialist agencies would gradually develop experience, expertise and confidence in dealing with individuals with drink problems appropriately and hopefully this would eventually have a knock-on effect of reducing the number of referrals to the community team as well as ensuring that the referrals that did reach the team where appropriate.

The commissioning department of Worthing District Health Authority worked up a proposal and job description along these lines for submission to the Joint Care Planning Group (JCPG) for joint funding by Health and Social Services. If successful
the proposal would have been funded from the financial year 1995/1996.
Unfortunately the proposal was unsuccessful and was not recommended for funding in the coming financial year. However, the committee felt that the suggestion had enough merit to be resubmitted for consideration for funding in 1996/1997.

Because of this unsuccessful bid the proposal was discussed once again in the Worthing Advisory Group on Substance Misuse on the 26th October 1994. It was here that the current proposal was first suggested and subsequently developed by Mr. Michael George (Manager Drug & Alcohol Services, Worthing Priority Care NHS Trust) Dr. Wayne Morgan (General Practice representative to the Worthing Advisory Group on Substance Misuse) and Dr. Chris Bentley (Consultant in Public Health Medicine and Chairman of the Worthing Advisory Group on Substance Misuse).

**Primary Care Development Post in Substance Misuse**

There is a considerable weight of evidence to demonstrate that general practitioners are more likely than other professionals to come into contact with people who misuse alcohol or drugs (e.g. Social Workers, Clinical Psychologists). General practitioners and other primary care health workers are well placed to recognise and identify substance misuse problems at an early stage and respond with advice, information or other brief interventions as appropriate. The development of recognition, assessment and intervention can be enhanced by the introduction of a specialist worker operating alongside primary health care staff to increase their skills and confidence in dealing with this client group.
Some practices have a larger number of substance misusing patients than others. Various factors may account for this. Some practices develop a reputation for a caring and flexible attitude to treating substance misuse and therefore attract more patients with these problems by word of mouth and personal recommendation. Geographical location also plays an important part. Practices located in areas of social economic deprivation are more likely to be overburdened with a variety of problems including substance misuse. Another factor is the geographical proximity to specialist substance misuse services. In piloting the idea of a primary care development post in substance misuse therefore it would be logical to base the worker in a practice which is identified as attracting a disproportionate number of patients with substance misuse problems.

Aims and Objectives

1) Working towards Health of the Nation targets in reduction of suicide, units of alcohol consumption and high risk drug use (sharing injecting equipment).

2) Reduction in levels of prescribing and prescribing budgets.

3) Prevention of long term substance misuse related morbidity.

4) Reduction in emergency care/admissions to hospital for substance misuse related problems.
5) To conduct an audit of levels of drinking/drug use in a general practice population.

6) To provide advice and information on drug and alcohol related problems for all individuals enrolled within that general practice.

7) To provide brief therapy interventions in conjunction with other members of the primary health care team.

8) To provide training for primary care staff in developing recognition and intervention skills.

9) To develop a protocol for appropriate referral onto secondary specialist agencies.

10) To record service uptake and output and conduct an audit of effectiveness to establish the merits of developing similar posts within other general practices within the District.

11) To assess and promote positive changes in primary health care staff attitudes to facilitate harmonious and effective work in addiction and substance misuse.

Implementing this proposal

A meeting was arranged on the 22nd December 1994 with
Dr. Gillian Strubey (West Sussex Family Health Services Authority)

Dr. Elizabeth Saunders (Worthing District Health Authority Public Health Commissioning)

Dr. Wayne Morgan (General Practitioner, representative on Worthing Advisory Group on Substance Misuse)

Mr. Michael George (Manager Drug & Alcohol Services Worthing Priority Care NHS Trust)

Mr. Ross Haffenden (Clinical Nurse Specialist Worthing Community Alcohol Team).

Having established and agreed that the proposal had definite merit, the meeting turned its attention to the possible sources of funding for the post. Dr. Strubey indicated that the FHSA had funds for general practices to provide enhanced therapeutic services to their patients and that an application along these lines would be viewed favourably. The full costs of such a post was likely to be in the region of £25,000 per year of which the FHSA might provide around 70%. The District Health Authority showed a willingness to consider funding any shortfall in the light of the training and liaison role which the post would provide. The application would, however, have to be made by a general practice and the post based within a particular general practice. The idea of “subcontracting” the development worker to other local general practices was discussed and no obvious obstacle identified. In this way some of the costs incurred by the post could be recouped by selling training initiatives and consultancy to other local practices. If the post was successful in achieving the identified aims and objectives it was felt that other practices might seek to develop a similar post thus expanding the resources available to help people with drug or alcohol related problems in the primary care setting.
WEST SUSSEX FAMILY HEALTH SERVICES AUTHORITY

JOB DESCRIPTION

Job Title: Substance Misuse - Liaison and Training post in Primary Care - Littlehampton

Reports to: Management Committee comprising:

General Practitioner from Base Health Centre
FHSA representative
District substance misuse service manager
Base Health centre practice manager
Clinical supervisor

Salary: Nursing Grade ‘G’, Senior Social Worker or equivalent

Based at: The Fitzalan Health Centre, Littlehampton

1. The purpose of the post

1.1 This is a development post, funded initially for two years, to establish the role and impact of recognition, assessment, counselling and brief intervention skills for substance misusers in the general practice setting.

1.2 The project aims to facilitate primary health care staff in the early recognition of and intervention in problems associated with substance use and misuse. The post addresses all classes of psychoactive substance including within it’s remit both legal and illegal substances, prescribed and over-the-counter medicines and alcohol.

2. Main Objective

2.1 Screening and Sampling Techniques

Using available screening tests and questionnaires, and by developing similar tools for specific local use, the post holder, in co-operation with practice staff at the Health Centre should seek to establish a baseline of substance use/misuse within patients attending the health centre. Postal sample surveys may also be conducted.
2.2 **Treatment**

The post holder will take on a selected caseload of individual and group treatment programmes in collaboration with permanent health centre staff to foster the development of treatment skills throughout the primary health care teams.

2.3 **Training**

The post holder will organise specific training opportunities, seminars and presentations for Primary Health Care Staff both within the base health centre and in local health centres within the Littlehampton area.

Training will focus on recognition, assessment, engagement and brief intervention skills as well as helping to develop. Protocols for appropriate referral on to specialist secondary or tertiary level services. All training output should be evaluated by participants.

2.4 **Establishing effectiveness and monitoring outcome**

The post carries with it the responsibility to thoroughly evaluate the impact of this new service in the primary health care setting. Evidence of health gains, reduction in morbidity and prevention through early detection and intervention will be essential in the strategic development of similar posts within the district and the case for continued funding of the current post.

Monitoring should include

- baseline measures of population morbidity
- service uptake
- level of training output and evaluation
- number of completed treatment programmes (individual and group)
- evidence of behavioural change measured in terms of levels of consumption
- levels of staff satisfaction within the base health centre and other participating practices
- feedback from client of the service.

3. **General Duties and Responsibilities**

3.1 To be an integral member of the primary health care team.
3.2 To liaise with the district-wide substance misuse service and attend team meetings as appropriate.

3.3 To assess patients needs, plan and implement appropriate interventions and evaluate the outcome of treatment.

3.4 To maintain up-to-date and appropriate records of caseload levels and training output.

3.5 To provide supervise placements for trainees from nursing and other appropriate disciplines.

3.6 To maintain an up-to-date knowledge of current research and practice in the area of substance misuse.

3.7 To develop and deliver training in substance misuse recognition, assessment and brief intervention skills to staff in primary health care.

3.8 To participate in the development, operation and evaluation of the liaison and training post in primary care.

3.9 To produce relevant fact sheets, leaflets, assessment tools and data collection forms as appropriate to the post, its dissemination and development.

3.10 To ensure the safety and welfare of self colleagues and patients and to be aware of and comply with local/national legal and policy requirements.
REALLY USEFUL KNOWLEDGE:

AN EXPLORATION OF THE BOUNDARIES CUSTOMS AND FOLK-LORE WHICH GOVERN THE RECREATIONAL USE OF ILLEGAL DRUGS IN A SAMPLE OF YOUNG PEOPLE

Research Component for Degree of Psych.D in Clinical Psychology

University of Surrey 1995

PART I
INTRODUCTION

Research into the recreational use of illegal drugs has never, arguably, achieved the prominence which it deserves. "Successful" recreation drug users may teach us more about treating problematic drug use than studying casualties whose drug use has become problematic, or studying abstainers. Recent surveys of drug use amongst young people (Balding, 1992 etc) suggest that the prevalence of recreational or dangerous drug use as well as the use of cannabis and hallucinogenic drugs has increased to epidemic proportions.

Measham et al, (1994) sampled a representative population of 776 young people between aged 14 and 15 years. They reported that 60% of the sample had been offered illicit drugs (principally cannabis) and that 36% reported trying one or more of those drugs offered. Hettiaratchy (1994) reported similar "offer" and "try" rates in a sample of nearly 4,000 college age subjects in Hampshire, UK.

Research which focuses on problematic or dependent drug use, therefore, fails to take account of the far larger cohort of drug users who maintain control over their intake.
Background

This research is a slightly serendipitous adventure into folk lore, knowledge base and tribal customs which govern this recreational drug use. The main corpus of research into controlled drug use dates back to 1970s and early 1980s. It has been established that social sanctions, rituals, drug taking environments and cultural determinants all exert control on quantity, frequency, type and mode of drug use (Zinberg et al, 1975, Zinberg, 1984). Presumably because it was the most topical drug of addiction, heroin is singled out in earlier studies (Powell, 1973, Blackwell, 1983, Crawford et al, 1983). In the 1990s, because of changing trends and fashions, new recruits to opiate use appear to be dwindling and the use of psychostimulants and hallucinogenics appears to have eclipsed the number of heroin users. While tracking down long-term recreational opiate users is the ultimate challenge to outreach research (George, 1993) there is an abundant sample of recreational stimulant and hallucinogenic users many of whom are willing and able to discuss the unwritten rules which provide the informal checks and balances to their drug use (Solowij et al, 1992, Clifford et al, 1991, Becker, 1973).

Historical Perspective

Wilks et al (1989) review a significant corpus of research which demonstrates a powerful parental modelling effect for drinking behaviour. The authors comment (p.627)
"As modelling theorists would predict, the drinking behaviour of mothers and fathers was the best predictor of adolescent male drinking of beer, which is by far the most heavily consumed alcoholic beverage".

However, this study deals with a behaviour for which there is, by and large, no parental model; the use of illegal drugs. What then are the influences and sources of knowledge which shape illegal drug taking behaviour? The evidence would seem to implicate strongly the role played by peers. Swadie and Zeitlin (1988) identify peers as providing both a behavioural model and a source of information. They continue: (p.154).

"....It seems that differences between users and non-users exist in so far as the response to such information is concerned".

Non users favour “professional” sources such as general practitioners, while users give more credence to information from other users or from ex-users. Neither group relied on parents as sources of information. The distinction which is probably being identified is that between people who “know what they are talking about” and those who do not. Predictably, in the Swadie study the only people who spoke positively of parental information or advice were those respondents whose parents used illegal drugs.
"My dad still smokes the ganja all the time. He still smokes it. But like my mum hasn’t really tried anything. I have a smoke with my dad every now and again which is quite cool..." (21 yr old female recreational user).

Grund (1993) studied the symbolic and ritualistic components of Heroin and Cocaine use in the Netherlands and noted that (p.295)

"the ingestion of Heroin by both chasers and IDU’s is subject to a fixed stylised and predictable behavioural sequence, which a user must master through practice, observation of, and instruction from more experienced users..."

These drug use rituals are instrumental in the self-regulation of drug taking and transitions between smoking or injecting or between Heroin or Cocaine in his subject sample were often associated with:

"attempts to regain control" (p.296)

Grund concludes that:

"...In contrast with stereotypical portrayals, it is concluded that the study participants put much effort in trying to control their drug use..." (p.297)
The recent work of Grund draws heavily on the research on controlled intoxicant use carried out by Norman Zinberg (Zinberg 1984). Zinberg’s seminal work influenced much of the subsequent research into the controlled use of drugs and deserves to be covered in some detail. He argued that “drug abuse” was an over-inclusive term. In doing so he challenged the 1970’s American middle class (predominantly white) attitude that the terms “drug use”, “drug misuse”, “drug abuse” and “drug addiction” could all be used, and often were used virtually interchangeably.

He took upon himself the task of establishing to the public and his colleagues in the medical profession that the controlled use of illegal drugs was not only possible but widespread. He advocated the investigation of moderate drug consumption as a tool to discourage abuse and inform research into the treatment of addiction rather than an attempt to encourage young people to use dangerous drugs on the basis that they were relatively harmless.

He pointed out that the historical legitimisation of alcohol use, experimentation, formal and informal teaching about appropriate use have all combined to produce a situation in the 20th century when most people use this drug harmlessly most of the time. This was not always so and presumably, if alcohol was an illegal drug, would not be the case today. It takes several generations for the appropriate use of a substance to become woven into custom, folklore and accepted behaviour of a society. This point is easily supported if one considers the devastating effect of the abrupt introduction of alcohol into such cultures as the North American
Indians or the Australian Aboriginal tribes. Zinberg’s argument is therefore simple and persuasive. The illicit nature of many drug substances prevents the natural process of socialisation and unconscious indoctrination of appropriate use through peer, parental and community modelling. Zinberg asks:

"...is it possible for formal education to codify social sanctions and rituals in a reasonable way for those who have been by-passed by the informal process, or does the reigning cultural moralism preclude the possibility of discussing reasonable informal social controls that may condone use? This question will remain unanswered until our culture has accepted the use not only of alcohol but of other intoxicants so that teachers will be able to explain how these drugs can be used safely and well. Teaching safe use is not intended to encourage use. It's main purpose is the prevention of abuse, just as the primary purpose of the few good sex education courses in existence today is to teach the avoidance of unwanted pregnancy and venereal disease rather than the desirability of having or avoiding sexual activity". (Pages 10,11).

The widespread belief that drug use, drug problems and drug dependency are virtually synonymous further complicates the picture. While Zinberg argues that abuse flourishes in the educational vacuum which illegality promotes, Davies (1992) points out that the widely held belief that drug use tends inexorably towards loss of control can become a dangerous self-filling prophecy. If people are taught that drug use leads to addiction, this belief
and expectation may generate the very pathology that it describes (Zinberg and Harding, 1982). Drug users will be more likely to see themselves, and be seen by professional agencies, as helpless, problematic addicts.

Thus a combined effect can be demonstrated which both denies the existence of controlled intoxicant use and promotes energetically the message that use results in uncontrolled use. These are presumably the beliefs and expectations which the novice drug user brings to their first tentative and ignorant experiments with illegal substances.

Despite these influences, there is increasing evidence for widespread successful recreational use of illegal drugs. Indeed, in some areas of the UK (McDermott and McBride, 1993), controlled users are being recruited and trained to “pass those skills onto others...”. The introduction of this type of “Peer Coalition” challenges drug workers to “...stop seeing themselves as the experts....” (ibid).

In Clifford et al’s (1991) sample of 683 American college students, a curvilinear relationship was identified between level of drug use and measures of life satisfaction:

“The greatest degree of self-reported life satisfaction is correlated with low to moderate usage of some drugs...”
Lower levels of life satisfaction were associated with zero drug consumption and moderate to heavy consumption. "A little of what you fancy" would indeed appear to do you good! The authors conclude:

"...it would appear to be counterproductive to insist that all persons be abstinent..." (p52)

**Recreational Drug Use**

Before exploring further the phenomenon of successful recreational drug use it is necessary to develop some working definition of recreational use which discriminates it from dependent, problematic or unsuccessful use.

In a useful paper on societal and professional issues surrounding recreational drug use, Solari-Twadell (1991) attempts a brave definition of this complex set of behaviours:

"...Recreational drug use is the voluntary use of either legal or illegal substances for the satisfaction to be derived from it or because of the perception that some personal or social value will be achieved by it. It is carried on in leisure time and has no work connotation. Recreational drug use is intended to produce pleasure and serves as diversion from more pressing and serious issues of daily living...." (p.499)
The main themes which emerge from this definition are those of fun, control and the social context of drug use. Recreational use is a diversion from or alternative to other aspects of daily life. It is not the focus of daily life in observation often levelled at dependent use. The recreational user perceives and employs the ability to make choices vis-a-vis times, types, quantities and contexts of drug use. Finally, the recreational user enjoys their drug use rather than seeing it as an unfortunate necessity, an affliction or disease, or a compulsive behaviour which exerts control over the individual (see for example Kreitman, 1986).

But what is the nature of the successful recreational users expertise? In what ways is this relationship with drugs generated and how is it maintained? Who are these people who rarely present to drug agencies and who would be more likely to define their drug use as recreational rather than problematic? In summary, this research attempts to address the question: What differentiates successful recreational drug use from problematic or dependent drug use?

**Method**

The research method follows broadly the approach to qualitative data analysis termed social anthropology. (Miles and Huberman, 1994). The defining characteristics of this research method are:

1) extended contact with the community to be studied.
2) focus of enquiry on individual's perspectives and interpretations of the world.

3) use of audio or videotapes rather than pre-structured instrumentation.

4) the distillation of patterns, languages or rules form the raw data.

5) the uncovering and exploration of meaning is typically based on successive observations and/or interviews which are reviewed analytically to inform the refinement of hypotheses and consequently the next step in the enquiry.

Miles and Huberman (1994) go on (p.9) to list the common features of qualitative analytical methods. Since these form the basis for the data collection and analysis in the first part of this study, they are here reproduced in full.

"...

- Affixing codes to a set of field notes drawn from observations or interviews.

- Noting reflections or other remarks in the margins.

- Sorting and sifting through these materials to identify similar phrases, relationships between variables, patterns, themes, distinct differences between subgroups, and common sequences.

- Isolating these patterns and processes, commonalties and differences, and taking them out to the field in the next wave of data collection.
• Gradually elaborating a small set of generalisations that cover the consistencies discerned in the database.
• Confronting those generalisations with a formalised body or knowledge in the form of constructs or theories...”

With all these considerations in mind, the instructions to the radio researchers who conducted the interviews were intentionally and necessarily to pitch the interview in a broad, general and non-directive way, using open ended questions to generate diverse discussion.

In many aspects, ethnography differs greatly from those research methodologies conventionally used in the drug and alcohol field. “Reality” is no longer a static entity accessible to objective study but a

“constant and on-going negotiation between individuals and groups, whereby social meanings are produced, transformed and abandoned...” (Moore, 1993).

Unlike conventional quantitative research methods which test hypotheses against accumulated data, ethnographic analysis is fluid and reflexive. It builds on ideas and observations formulated throughout a study and research problems are transformed, adapted and revised throughout the research process. Ethnography is data-driven whereas quantitative methodologies tend to be construct or hypothesis-driven.
To say that the ethnographic researcher enters the field with a completely open mind free of prejudice or preconceived ideas would, however, be an exaggeration. Assumably the research endeavour implies a pre-existing interest in the particular area of research and expectations and beliefs are likely to exist within this interest. Nevertheless, ethnographic research endeavours to avoid setting firm parameters, preferring to allow the field and the data which it produces to shape the research agenda.

Social ethnography was chosen as the research method to reflect the hypothesis generating rather than hypothesis testing nature of this research. It has an established track record as a valuable methodology for field studies of illicit behaviour. Power's work (1989) provides an excellent example of the illicit drug scene in London in a similar context where a more formal or structured approach might alienate the subjects and even put the researcher at some risk. Open ended and non-directive discussion provides a less threatening alternative.

The qualitative data generated in part 1 will be used to develop a questionnaire for the quantitative section of the work. This was always the research intention and utilises the proven technique of triangulation (Miles and Huberman, 1994) in which data observed from one stand point or generated by one technique are checked and consolidated by a different stand point or technique. It is increasingly recognised that the artificial divide between quantitative and qualitative research methods is no longer
appropriate and that combining the two approaches, as has been attempted in this research study, potentially generates fruitful results (McKeganey, 1995; Heath, 1995).

Semi structured tape recorded interviews were held in pubs and clubs on the South Coast of England with 26 young recreational drug users. The radio journalists commissioned to conduct the interviews were briefed to lead the discussion towards the following areas:

1) The parameters which govern the types of drug used, quantities of drugs used and frequency of drug use.
2) The customs which had developed and were observed within the users' peer group relating to drugs and drug use.
3) The sources of the drug related knowledge which informed and helped to govern the extent and type of drug use as well as the relative weighting or value bestowed on these various sources of knowledge by the user.

The typescripts of the semi-structured interviews were then analysed for content to "map-out" the self-imposed and external boundaries which governed individuals drug use, the lessons they had learned, the social and safety taboos and the sources from which this folklore had been accumulated. A "coding frame" of core constructs, subthemes, and elements was used to sort the data into homogenous blocks. These
combine to form family trees, associated in meaning and significance. (See tables 6-10).

The Sample

The two radio journalists commissioned to conduct the interviews were familiar with the entertainment scene around the town of Brighton on the South Coast of England. The radio journalists were reimbursed for their contribution. They were instructed to conduct and facilitate informal discussion groups with young recreational drug users. The groups were gathered by three main methods:

1) Young people who frequented particular music venues including pubs and clubs and who were approached at random.

2) Students outside one of the colleges of Further Education first contacted on the street and then asked to an informal meeting at a public house. These individuals had also been asked to bring a friend if they so wished.

3) Acquaintances of the two radio journalists mainly interviewed in their homes or in the homes of the journalists. They, too, had been asked to invite interested friends if they wished.

These contacts eventually formed the cohort of 26 respondents. All respondents were told the aim of the research.
Because of financial and time constraints, it was decided that between 20 and 30 participants would be adequate for this study. The radio journalists reported that they had no difficulty in recruiting agreed participant numbers with the exception of two potential participants who were approached but declined on grounds of confidentiality. The respondents spent a lot of time discussing the issues with only minimal prompting by the interviewers. This, perhaps, is one of the hallmarks of recreational drug users. In an earlier pilot study of occasional Heroin users (Powell, 1973) the author recruited 12 recreational Heroin users after advertising in local newspapers in the Boston area of North America. The advertisements resulted in nearly 100 phone calls of which, only 12 subjects complied with the research criteria. The author comments

"...not being able to pay subjects for spending approximately a day of their time did not result in the loss of any occasional Heroin user. However, several Heroin addicts said that they would not participate in the study (had they been asked) without being paid..." (page 587).
Anecdotal discussion of this point with clinic attenders confirmed the impression that an addicted user would automatically seek financial advantage in any research undertaken whereas a recreational user would be more likely to take part out of interest or natural curiosity.

SAMPLE CHARACTERISTICS

Because of the informality, anonymity and non-directive nature of the research, the profile of the subject sample is necessarily sketchy and incomplete. This is both a strength and weakness of open ended research which encourages the respondent to explore their own agenda rather than follow the agenda determined by the research worker.

RESULTS

The author listened to the recorded interviews and conducted a content analysis of the typescripts which ran to 176 pages. Gradually key themes and issues emerged. Subsequent comparison with a second researcher revealed a reassuring measure of overlap. Core quotations dealing with each of the identified themes were selected to support the text and discussion.

Most subjects were in their early twenties. Four subjects were younger than twenty and one older than twenty. The youngest subject was 16 years old and the oldest 34 years old.
Although two subjects reported first using illegal drugs at the ages of 11 and 12 respectively, the majority reported their first illegal drug experiences between the ages of 14 and 16. Two subjects reported using their first illegal drugs at the age of 20.

Nineteen talked about the first illegal drug they had tried. This had been Cannabis in 15 cases, Ecstasy in 2 cases, Amphetamine in one case and LSD in one case.

All subjects were asked routinely which drugs they had ever used. The following pattern emerged (see table 1).
TABLE 1  (n = 26)

RESPONDENTS REPORTED DRUGS EVER USED

<table>
<thead>
<tr>
<th>DRUG</th>
<th>NUMBER</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis</td>
<td>23</td>
<td>88</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>21</td>
<td>81</td>
</tr>
<tr>
<td>Amphetamine</td>
<td>19</td>
<td>73</td>
</tr>
<tr>
<td>LSD</td>
<td>17</td>
<td>65</td>
</tr>
<tr>
<td>Cocaine</td>
<td>9</td>
<td>35</td>
</tr>
<tr>
<td>Magic Mushrooms</td>
<td>7</td>
<td>27</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Heroin</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Ketamine</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Poppers</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Crack</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Methadone</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>

Incomplete data sets include “Age of first use” (table 2), “Drug first tried” (table 3), “Age of subjects” (table 4) and those who volunteered information on “Drugs avoided” (Table 5) or those drugs which they would consciously refuse if offered or available.
TABLE 2  (n = 26)

REPORTED AGE OF FIRST EVER DRUG USE

<table>
<thead>
<tr>
<th>YEARS OF AGE</th>
<th>NUMBER</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>12</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>13</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>14</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>15</td>
<td>8</td>
<td>31</td>
</tr>
<tr>
<td>16</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>17</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>18</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>19</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>20</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Not known</td>
<td>6</td>
<td>23</td>
</tr>
</tbody>
</table>

TABLE 3  (n = 26)

RESPONDENTS REPORTED FIRST USE BY DRUG TYPE

<table>
<thead>
<tr>
<th>DRUG</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis</td>
<td>55</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>7</td>
</tr>
<tr>
<td>LSD</td>
<td>4</td>
</tr>
<tr>
<td>Amphetamine</td>
<td>4</td>
</tr>
<tr>
<td>Not known</td>
<td>30</td>
</tr>
</tbody>
</table>
### TABLE 4 (n = 26)

**AGE DISTRIBUTION OF RESPONDENTS**

<table>
<thead>
<tr>
<th>AGE</th>
<th>NUMBER</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>17</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>18</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>19</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>20</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>21</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>22</td>
<td>7</td>
<td>27</td>
</tr>
<tr>
<td>23</td>
<td>3</td>
<td>12</td>
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<tr>
<td>24</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>25</td>
<td>1</td>
<td>4</td>
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<tr>
<td>26</td>
<td>2</td>
<td>8</td>
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<tr>
<td>27</td>
<td>1</td>
<td>4</td>
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<tr>
<td>28</td>
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<td>0</td>
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<tr>
<td>29</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>30</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>30+</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Not known</td>
<td>2</td>
<td>8</td>
</tr>
</tbody>
</table>
TABLE 5 (n = 16)

RESPONDENTS REPORTED AVOIDANCE OF DRUGS BY TYPE

<table>
<thead>
<tr>
<th>DRUG TYPE</th>
<th>NUMBER</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin</td>
<td>14</td>
<td>87</td>
</tr>
<tr>
<td>Cocaine</td>
<td>4</td>
<td>25</td>
</tr>
<tr>
<td>Crack</td>
<td>4</td>
<td>25</td>
</tr>
<tr>
<td>Ketamine</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>GHB\textsubscript{f}</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Any Injected</td>
<td>1</td>
<td>6</td>
</tr>
</tbody>
</table>

It is notable that the mode age of first drug use is 15 years (see table 2) while the mode age of respondents (table 4) is 22 years. The implication is that this cohort had used drugs, on average for approximately seven years between first initiation and the present survey. This in turn suggests that we are not just looking at a group of young people who are too young, or whose drug use is too brief to be problematic. The incomplete data suggest a pattern of sustained control over a number of years.

Cannabis, Ecstasy, Ampethamine and Acid (LSD) emerge as the most likely recreational drugs in this sample. Approximately one third of the sample had used Cocaine and one quarter had used Magic Mushrooms. Predictably, opiate use reported low and surprisingly Crack Cocaine was only reported by one individual.
Some subjects mentioned drugs they would never use although once again this data set is incomplete. Fourteen subjects (see table 5) volunteered the information that they would never use Heroin, four indicated an unwillingness to use Cocaine, four mentioned that they would never use Crack Cocaine and two mentioned that they would never use Ketamine (special K). This information was volunteered by a total of 16 subjects from the survey sample.

The excerpts which accompany the following themes and sub-themes are reported verbatim from the original material and have not been altered in any way. Whilst the grammar is sometimes inaccurate and the turn of phrase robust, it has been the author’s intention to render a faithful report of the selected material without imposing an academic bias which might radically alter its flavour and impact.

No attempt was made to investigate the validity or otherwise of any of the information given to the interviewers. It is therefore possible that the sample may have sought to “fake good” and appear to be more in control or having a better time than was actually the case for the benefit of the interviewers. If this is the case it emphasises once again that “fun” and “control” are highly valued attributes of recreational drug use which may be aspired to by some who have not attained them. There is a further check imposed on the validity of the data. The categories, themes and sub-themes were identified as significant because these issues emerged again and again. While only the most specific and cogent examples of the text are used, the
themes to which they refer emerge again and again in the subject - subject and subject - interviewer discussions. Some themes (for example the risk of AIDS/HIV transmission) are notable by their absence. It is unlikely, if this was a central issue, that no reference would be made to it throughout the entire typescript.

ANALYTIC THEMES

The themes which emerged were classified into an hierarchy consisting of main categories (table 6), themes and sub-themes (tables 7, 8, 9 and 10). This “road-map” of motorways, arterial routes and country roads provides a working sketch of the internal and external boundaries which govern the establishment and maintenance of controlled recreational drug use.
INFLUENCING AND CONTROLLING FACTORS IN 
RESPONDENTS REPORTED DRUG USE

A * Sources of Knowledge

B * Risk Reduction

C * Values and Beliefs

D * External Controlling Factors

TABLE 6

201
A SOURCE OF KNOWLEDGE

1. Experiential Learning
   1.1 Substance Experimentation
   1.2 Dosage experimentation
   1.3 Limiting experiences

2. Observational Learning
   2.1 Peer example
   2.2 Information from friends

3. Database Source
   3.1 Folklore
   3.2 Academic Research
   3.3 Parental advice
   3.4 School
   3.5 Media

TABLE 7
The first of the main categories, SOURCES OF KNOWLEDGE, contains information about drugs, their effects and the sources from which these data have been accumulated. The following themes and sub-themes emerge (see table 7).

1. EXPERIENTIAL LEARNING

Experiential learning (A1) emerges as a major influence in relation to drug use. This theme deals with experiences which the subjects had themselves encountered in relation to drug use. These are therefore first hand experiences and appear to draw their power and influence from this immediacy.

1.1 Substance experimentation

The subjects had experimented with a variety of substances (for an overview see table 1). There is an underlying attitude that if an individual has not tried substance X, he or she has no right to be either promoting or deploring its use. Many had approached this experimentation with an open mind, eager for new experience and relatively unafraid of the consequences. Ignorance is seen as carrying greater risks than experimental use itself.

"The unawareness of taking something is probably more dangerous than anything else. Like once you've taken some acid like, when I was about sixteen and the first time I took it, it was all what are we going to do,
what's this and like that. Once you experience it, you know what it is and you can go and do it. It's like starting a new job”.

“When I first started taking drugs it was a sense of exploration and a sense of you've got to try everything once and that there was no way I could possibly comment on them or have an opinion on them if I hadn't experienced them and that was why I, you know, when I was first offered it, I'd have a go at almost anything. I think it's been very useful and I've learnt a lot through doing that”.

1.2 Dosage Experimentation

Within the aetiology of recreational drug use it would appear that once a preferred substance has been chosen, or in the process of its choice, dosage experimentation takes place. It is not always assumed that “more is better” but sometimes this is a lesson that has to be learnt. For most respondents this process of titration was a conscious and almost scientific process. They were aware when the optimum dose had been exceeded and would modify their intake appropriately. In some instances (for example getting drunk and experiencing a hangover the following day) this experience was repeated on a number of occasions before the behaviour was modified.

“I just upped what I was taking and experimented further and further until I reached a point when I thought, no, this doesn't feel so good, this is
becoming unhealthy, the physical come-down off this isn't worth it. It was just a gradual process of trial and error”.

“The first time I took them, I took just twenty and I got a little bit of a buzz off it. But I'd never done them before. So, then I done more and more”.

“The same with speed you kind of know like a gram is enough to keep you going really nicely for the whole night. Take more than a gram and you're overdoing it. And that's how I sort of work it. You know that you actually don't have to take that much more. You have to think, yeah, I'm overdoing it”.

1.3 Limiting Experiences - Going Too Far

Not all dosage experimentation was conducted purposefully. Some subjects had made mistakes and in a number of cases the unwanted experiences had been frightening. In some instances they occurred with familiar drugs which had been used on a number of previous occasions, and in some instances the drug (for example Ketamine) was being used for the first time. However, while these are predominantly negative experiences, they lead, in most instances, to increased insight, greater control, and the confidence which accompanies greater understanding of drug types and effects.
“I used to do a few Es but I haven’t taken any for a little while. Not since I done a couple of snowballs one night and it was just dodgy, poisonous. That’s it. I’m just smoking a lot these days”.

“I had a bad trip once. That was about just over a year ago and that put me off taking acid for a long while. It was about six months before I actually took acid again. Even then I only took a small quantity. But that was a reflection of my state of mind”.

“Are there any drugs that you’ve taken that you’ve decided you’re never ever going to do again?” “Yeah, one. Ketamine. Special K they call it. I felt paralysed for twenty minutes after a line of it and it was horrible, I didn’t like it at all. I was in fear of my life. So I wouldn’t recommend that. I don’t even know what it is. Some people told me that it’s horse tranquilliser. But I dunno. It’s horrible anyway”.

“Cocaine, I always thought I could handle. Hash, ecstasy, things like that... very easy designer, sociable drugs. Then I discovered Heroin. I had actually discovered that in my younger years, but I left it alone, again around twenty-six, twenty-seven, I lost control completely. I didn’t really know what was going on at the time. That actually stopped me taking hard drugs”.

“I just reached a point where I realised that it was affecting my personality and I was becoming very withdrawn and very insecure about
things, but mainly very insecure about relationships that I had and there
was a couple of times when I was taking acid and there was one particular
time that I remember where I just spent eight hours in a room full of
people and I didn’t say a word, I was just too scared and withdrawn to
actually sort of actually participate in what was going on. Very, very
frightening, I just couldn’t say a word, not through anything physical, I
was just very worried about what people would think if I said something.
Whether I’d get shot down. That’s really the time when I decided doing
this was really going to fuck me up bad”.

“I really enjoyed taking drugs at times, but later when it became quite
excessive, taking acid and smoking a lot and taking mushrooms daily,
that’s when it got a bit out of hand and I started to get very paranoid and
insecure and that’s the time when I don’t know, I thought it was probably
time not to take drugs any more. That wasn’t very interesting”.

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2. OBSERVATIONAL LEARNING

This data set includes as it were, second hand experiences which, while less powerful than those gained at first hand, have greater influence than academic information, unsubstantiated fact and rumour, and plain hearsay.

2.1 Peer Example

The example offered by those around the individual can be either positive (pro-drug) or negative (anti-drug). The ubiquitous principle emerges that the more significant the model, the more significant the modelling. The drug experiences of siblings, partners and best friends are more persuasive than those of distant relatives and acquaintances. Congruence also emerges as a powerful influence. If a number of acquaintances have a similar drug experience it is more likely to be believed in comparison with drugs and dosages when the evidence is contradictory or equivocal.

"A lot of people have been brought up on drugs. Taking drugs is second nature, it's completely normal, you know. A normal social thing to go out to dinner with your friends, have some drinks and then take drugs. You know, its completely normal. How can you change a whole culture that actually believes that"?

"My sister's really fucked up about it. Like she's constantly on drugs the whole time. And she's like left home and stuff because she's really ratty and stuff. And I don't want to get into heavier stuff like she did. Trips like
every day. Really bad. So I don’t want to... I keep it every weekend or something”.

“Fucking nightmare. Anyway this guy had got hold of some poppers. I mean, he was obviously hyper-ventilating anyway and he just went blue, and he staggered along the car and he was banging things...it was really quite frightening. And, I dunno, so it put me off poppers”.

“I’d also stop if any of my friends had a terrible experience on speed, acid, ecstasy. If I was there and had experienced it myself and seen it, I think I’d stop or cut down radically”.

“I’ve seen people on smack and they just don’t look like they’re having a good time. You know, they’re just... so that’s what I’d never do”.

2.2 Information from Friends

In some cases the subjects had not witnessed drug related events (positive or negative) but had sought or obtained information from friends relating to experiences which had happened at another time or place. Similar influences emerged. The more significant the informant, the more trusted the information and therefore, one would assume, the greater the influence on the recipient.
"It's been proved these days that cannabis is like a herbal remedy for a lot of things. It's good for asthma things. They're growing some, aren't they"?

"You pick up information here and there when you start getting into drugs and some of it's bullshit, some of it's truthful, and you have to hope that the people you have around you, who are supposed to be experienced, are actually experienced and not just feeding you crap, just talking bullshit. You've just got to learn by experience. If you have a dodgy E, then you've gotta sort of learn the hard way really. And obviously not take too much of anything you're not sure about".

"Whose information do you trust"? "Um, friends probably. Best people to trust".

"But my brother's great. He's just done about everything, almost. He's a bit cagey about it but he'll tell you, like some good times and some bad times. He won't ever offer advice about it unless you ask him. Best way to be, rather than saying, no you shouldn't do that, you shouldn't do that".

"Before I took anything I talked to loads of people about dealing with different drugs and how they worked, because I was petrified of the side effects. I asked all the people to tell me what the effects were of each drug at different times in my life, so I would be able to deal with it".
3. DATABASE SOURCES

These sources of knowledge are less influential than those deriving from experience or observation. However, this information, some of which is whimsical to the point of fantasy, forms a significant part of the portmanteau of dubious facts, influences and attitudes which the recreational drug user carriers around.

3.1 Folklore

This information is rarely attributed and often unattributable. Little of it is of any value and some is frankly misleading. It’s attraction probably arises from it’s sensationalism. It concerns plots to create races of supermen, hospital staff driven to Amphetamine use and Ketamine in Bovine transportation. Regrettably, the drier and less imaginative information contained in the average drugs leaflet compares unfavourably with the examples listed below.

“Well, I’ve had like, somebody once said to me if you’re ever having a bad trip or something never go to St. John’s Ambulance. They’ll take you straight to the police”.

“Smack Es generally give you wobbly legs and then on come down you feel really gouchy stomach-wise. You just feel really not too good. You’re
more prone to get paranoias on them as well 'cos they're mixed with other stuff. If it's good E you do not get paranoia”.

“Amphetamines do physically damage you, but with acid there isn’t even one recorded case that it actually physically damages you. It mentally damages you, ‘cos it can cause schizophrenia”.

“Ketamine kills cows.... 'cost they keep injecting them when they’re moving them up and down the country. It’s a very dangerous thing to get”.

“Yeah, it’s not supposed to be orally taken. You’re supposed to snort it”.

“If you take acid, it’s like its supposed to have thirty-two parts to it, it’s now got sixteen parts to it, sixteen chemicals make up acid or components”.

“MDMA or Adam was available on prescription over the counter in America in like ‘76, ‘78, ‘79, ‘80, ‘81 and ‘82. When it was first used really”.

“I think the statistic is about nineteen per cent of doctors and nurses are amphetamine...they work on amphetamines, they work such long hours. No one can function for a 112 hours working week unless they snort 12 grammes of speed. It’s as simple as that”.
“The American soldiers, especially in the deep jungles, they’d get a shot of Ketamine and run videos or films of North Vietnamese equivalent of the Pol Pot and hate messages were induced. And they’d just send them back out in the jungle and any Vietcong would end up being riddled with bullets. It was used as anaesthetic and an analgesic. It just puts you in a coma”.

“You just need a pipe and you put a bit of ash on the gauze to make a bed and you crumble a really small part of the E into dust on top of the that and you just light it. And you’re supposed to get like an aniseed taste if it’s a good E. You’d don’t get it if it’s a bad E”.

“Well, also it’s been... people die of heart attacks. That’s what it does. Amyl Nitrate speeds up the heart and makes the heart beat perhaps three and a half, four times faster and I’m sure there must be documented cases of people who’ve had heart attacks or passed out and been hit by a bus or something”.

“There’s some guy in the States, who with his leg in plaster, beat up four coppers who were trying to arrest him, using his leg as a club, put three of these coppers in hospital. You can imagine it actually, because some of these drugs do give you a feeling of immense power. It’s short lived, but apparently MDMA was first refined in the First World War for the army. They were trying to create a race of superman who could go in the trenches and be unstoppable. It was a German scientist who first designed
it, but it turned out to be some kind of love drug when it was originally envisaged as something to make people fight. So you never know do you”?

3.2 Academic Research

Some respondents preferred to trust the written word. Unfortunately the merit of the information appears to derive from its obscurity rather than its availability. The contention that high profile drugs information is dismissed as propaganda deserves further investigation.

“There’s a really good manual, I can’t remember the name of it, but it’s available to doctors and people who work as nurses - I can’t remember the name of the book, but I had one of them and sold it on. And you can read up on various things you can get from the docs and get a really good high off”.

“Well, I read. I have an awful lot of literature about it. I make a point of... I wouldn’t take any drug unless I knew everything there was to know about it, everything that had been written down about it”.

“It took me a long time, a lot of research, to find out what, in actual fact, was in MDMA or ecstasy and how it works and how it affects the brain, and it took me a long time to search through various books to find that out and I wanted to know that information”.

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“I just ended up having to dig up some imported book from America. In order to find out about it I had to get a book imported from America from a dodgy London bookstall. You know, that was because I was specifically interested in it. Most people don’t give a damn and don’t know, which is why, I think, you get so many people making so many mistakes”.

3.3 **Parental Advice**

Whilst parental attitudes and information are frequently cited by the subjects in the sample, rarely are they a valued source of information. They are either dismissed as being reactionary or praised for their laissez-faire attitude. Very few parents had been drug users themselves and therefore positive or negative modelling was unlikely. The hypocritical and contradictory distinction between legal and illegal drugs emerges in the text.

“But one person I wouldn’t tell is my dad, because he’d just kill me straight away. If I was smoking a cigarette he’d still kill me”.

“My dad’s always buying me drinks. If he found out I’d ever had a joint, he’d probably like hit the roof, you know. Which is like this really bad thing that old people have got. They just really don’t understand about the drugs at all”.

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"The only place my parents get their information, as far as I can tell, is all the leaflets that they keep giving me at every opportunity about drug use".

“And I do talk to my parents about my drug use to a certain extent even though I know they’re particularly anti. If only to reassure them because I think they’d rather hear me talk about it sensibly than like think it’s something I do illicitly”.

“They’re really easy about it. Really. They’ve said, be careful, don’t take too much. Try it, we know you’re going to do it anyway. But that’s a rare thing to find. Not many parents do that at all”.

“My parents were the same. Like, if you’re ever going to do drugs or whatever...and at the time I thought, oh god, here we go...just get them from me, ‘cost I’ll get the best and they’ll be OK. So you won’t be getting any crap or anything. Just do it wisely”.

“Parents have been OK about it. Take it easy, you know, don’t do anything stupid and we understand you’re going to do it, but just take care of yourself, basically. And school...they were dead against it of course”.

“My mother once came home one New Year’s Eve and my then boyfriend and my best friend and my sisters and I were up in my room burning joss sticks to disguise the fact that we were smoking fags and she came home
and she was on the phone to the fucking rehabilitation centre immediately. She makes absolutely no distinction between category A or category B drugs. So hence I find her attitude rather, kind of uninformed".

"The only conversation I've had with older persons concerning drugs, they've been totally anti without ever having taken it, which is dangerous I think. To talk to people about drugs without having taken them...I'm not saying you can't give advice but if you've taken something they'll say you shouldn't have taken it rather than talking about what actually happened, to help you if it happened again. You've got to accept that people are going to take these things. So that's the only conversations I've had with older persons".

"My mother once said to me if we were going to inject heroin or cocaine we shouldn't use a needle with a diameter of more than 0.5mm. That would ensure that we didn't get any blood clots and we have to have limbs amputated and things. That's what she told us and it's probably the most stupid piece of information I've ever heard in my life".

"Just be careful was basically all she said. Which was really good because if parents go, oh no, you're grounded for god knows how long, you just go, oh fuck off, I'm not listening to you. But if she sort of says, OK I know you're doing it, I rather wish you weren't but I can't really stop you, then you think, actually, she obviously cares about me so I'm not
going to do anything really stupid. She's given me the benefit of the doubt and you don't ruin it, take advantage of it. It's really good”.

3.4 School

Our sample dismissed formal education as a source of drug related knowledge. This data source was mentioned infrequently and only in a negative context. The information was described as tardy, inappropriate and uninspired. The arguments for improving the role and extent of drugs education within the school curriculum have been rehearsed elsewhere. Our findings lend further support to the inadequacy of the current system.

“I came into contact with drugs before school’s even told me about it”.

“At the school I was at the teachers weren’t interested in actually learning us. ‘Cos I mean everyone was so like we don’t want to do this, it got to the stage where they didn’t even bother teaching you anything, let alone teach you about drugs and that. It was, we don’t give a toss really. It’s your life. But it goes with...at decent schools you would be, they wouldn’t be able to get away with that, an you’d be taught. That’s all it stems from, it goes right back from places like that, I think anyway”.

“Did you get any information at school about drugs”? “Well, yeah. But it was just heroin, kind of jabbing needles into yourself. you know hard
core drugs. That was the only kind of things they talked about. I mean, acid wasn’t mentioned or ecstasy, anything like that”.

3.5 Media

The subjects in our survey did not rate the media highly as a source of drug related knowledge. Only one programme is mentioned and immediately discredited. It is possible that the greater realism offered in contemporary programmes about drugs will have a greater influence on the recreational users of the mid to late 90’s.

“When they gave the drugs information it was like Zamoh from Grange Hill who turned white, and like blue, and who was really spotty with a heroin overdose. But, that’s the information we’re given. Which is, like not truthful at all. It’s not realistic”.
B. RISK REDUCTION

1. Quality Control
   1.1 Known dealers
   1.2 Adulteration

2. Intake Control
   2.1 Danger of Addiction
   2.2 Retaining control
   2.3 Formation of tolerance

3. Safe Use
   3.1 Mental Health Risks
   3.2 Physical Health Risks
   3.3 Safety Zones
   3.4 First Aid

TABLE 8
B RISK REDUCTION

The second category which emerged from the raw data contains the information, experiences and practices intended to minimise the dangerousness of drug taking. By definition, recreational drug use should maximise pleasure and minimise pain. Some of these strategies focus on identifying and reversing the trend towards escalation of use. Others deal with mental, physical and environmental risk and contain advice about dealing with the bad drug related experiences of self or others.

1. Quality Control

Illegal street drugs are not made to controlled pharmaceutical standards. Their very dangerousness arises out of uncertainties as to content and purity. In an uncertain world there are measures which the recreational user can easily employ to minimise the risks which accompany the use of substances of uncertain content.

1.1 Known Dealers

The first and simplest measure is to buy drugs only from known dealers. Anecdotally, individuals who have been “ripped off” have bought from strangers. At best, harmless inactive substances are substituted at worst dangerous poisons are consumed.
"All the people I get drugs off are good friends and stuff, so they'd never give me a bad cut anyway and they're not really into doing bad stuff. Unless, say, they got it off of someone else. I've never had any bad deals in anything."

"I always get from one source and he's always sound. If he does step on it, it'll only be with like glucose and it'll only be like three grammes to half an ounce. But he doesn't do that much. Acid, I only get acid off one guy and he is safe, he is like really trustworthy. If he gets different trips in, he'll say how strong they are, you know. If it's pub acid or club acid. Sometimes he'll say, if you're going to take one of these trips don't go to a pub or a club, stay inside or go out to the countryside. So I just pass on what they tell me."

"I mean, if someone gives you a white tablet, it could be anything, couldn't it? You're only going to get it from someone you trust, or someone who you can go round and smash their face in if it's not the right stuff."

"I'd never buy drugs from anyone I didn't know. Ever. If somebody walked up to me and goes, here do you want an E, do you want some speed? I'd just go, no. a) you don't know who they are and it's probably very very expensive. So I'd only ever buy it off people I knew and knew well."
"Would you try it"? "Maybe, if it came from a good source". "What source would you say was a good source"? "Um, just people I know, whose opinions I trust, that weren't just flogging it to me for the money side of it".

1.2 Adulteration

As one respondent declares; "you're never going to stop people cutting drugs". It is important for the recreational user to realise that this is the case and to be aware of some of the risks associated with the adulteration of illegal drug substances. In times of scarcity the practice of adulteration escalates while in times of plenty it diminishes. This introduces another element to the Russian roulette of drug use. In the United Kingdom there have been (1993, 1994) fatal overdose epidemics in London and Bristol associated with particularly pure batches of Heroin. It is to be hoped that the wide media coverage that these events have prompted has done something to alert the drug using population to the increased risk specific to drug types and localities.

"It's really bad, you know what I mean. I'd rather have just the three per cent of pure speed than all the rest of the crap that makes it look like a gramme".
“With ecstasy or MDMA. It got to the point where people were knocking up these, in little houses in back streets, they were knocking up thousands of these tablets and lacing them with anything they could get hold of. I’ve heard of ecstasy being laced with strychnine”.

“Yes, acid’s being cut with strychnine...E’s with Ketamine/Heroin... hash with plastic/henna....things like that. You’re never going to stop people cutting drugs”.

2. INTAKE CONTROL

The issue of control runs like a thread which links the various aspects of risk reduction. Addiction, tolerance, escalating intake and over-dose risks are identified as dangers to be avoided when possible. One of the probable hallmarks of successful recreation use is the recognition of “drifting into dangerous waters” and the self imposed corrective measures which this insight prompts. Various examples of this recognition and internal correction are contained in the interview data.
2.1 Danger of Addiction

Far from dismissing addiction as a myth or, like serious road traffic accidents, something which only happens to other people, the cohort of recreational drug users recognise it as a reality to be avoided.

“I don’t like to be on that drug that long. So if I’m like on speed for days on end I feel I might be getting a little bit addicted here - which is what you don’t want. I’m quite good about just stopping and then carry on”.

“What would you never try”? “Heroin and crack and all the drugs that are much more addictive”.

“Crack and heroin is now coming up, especially over in America. I mean, it’s er, given to laboratory animals. They’re addicted after one dose of these hard-core drugs. So, I don’t think I’d touch those. I wouldn’t want to, unless I was administered them unknowingly”.

“Heroin and smack and things like that, I wouldn’t even bother with. Waste of time”. “Why”? “Why? because if I like it I’d probably be hooked and I wouldn’t be able to finance it. And I’ve seen a few people as well and they’re just a state...it just doesn’t look worth it....all haggard and skeleton looking”.

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“If I took a trip, I'd feel that I'd have to go on another one, 'cos I'm pretty gullible and if I took one I'd know the experience and I'd trust myself and I'd think, no that's not going to do anything to me, I can do it now. I can do another one whenever I want. And I'd just go on like that. I'd probably progress”.

“Why wouldn't you do coke or heroin”? "It just seems a lot worse than anything else. I don't think whether it is or not, really. But, like, you can get addicted to it and I just wouldn't want to do it. A lot more money too”!

“So what are your feelings about ecstasy now? Would you spend money on ecstasy”? “On a very special occasion”. “Actually I like it an awful lot but the reason I don't is because I like it too much and when I come down, I get so upset that I can't have the feeling again. It's too nice, so I don't spend my money on it because I'd end up getting incredibly addicted to it. That's why for me, to be honest”.

2.2 Retaining Control

Control, more than any other individual factor, appears to mark the boundary between recreational (non problematic) use and dependant (problematic) use. To feel in control is the hallmark of
success, to loose control the hallmark of failure. The successful
drug user becomes adept at identifying control issues within their
own drug use and that of others. It is tempting to speculate that
our subjects may have found it easier to identify loss of control in
their peers than in themselves.

"What about E? Have you ever done any E"? "Once, but I didn't
like it". "Why not"? "I didn't feel in control".

"Pretty clean young kids are dancing, dressing, being part of the
music scene and slowly like, whittling away whatever income they
have on drugs. Everything starts to change. They don't actually
realise that it's changing. They're more and more into the scene
and they're enjoying it and really the drug is taking over in my
opinion. I'm only saying it on the basis that I've done it myself.
And I've seen it and I've observed it. That's pretty scary".

"No. 'Cos if you've got control over it and, I mean, I've been
taking them for like five years, and I've got complete control
because I could stop like right now. And I could handle it, no
problems".

"There's nothing interesting about losing that much control, it
looks very frightening. I just have this image that this guy at about
six in the morning is going to realise that he's cold, broke, lonely,
lost and out of his head and that kind of thing is a classic case of, I think, he's openly made a mistake”.

2.3 Formation of Tolerance

The phenomenon of tolerance or habituation is widely recognised in our subject sample although technical terms are never used. The way in which tolerance is described in the following interview excerpt illustrates the way in which it has been discovered experientially or anecdotally rather than assimilated as technical jargon from a text book. That which the professional drug worker refers to as habituation, the user labels as “not getting the reaction” or “building up a resistance or taking longer to get that feeling”. Drug workers are in danger of obscuring communication with drug users by replacing the terminology of real experience with technical jargon.

“The whole idea is to have an altered state, so if you take a drug all the time then it loses it's excitement 'cost it's not an altered state any more. Being straight is much more exciting if you've taken drugs for the last few days or a week just because it's somewhere that you haven't been for a little while. So that's a good reason why people don't carry on taking drugs especially like recreational ones as we know”.
"I mean, once a week for an E, if you're doing it over a long period of time would be a ridiculous amount. I mean, there'd be no point to it either, because you wouldn't get the reaction, it'd be natural to you. There'd be no real point in it. And that would have physical dangers. Without a doubt".

"It's like anything, you build a resistance up to it. The next day you drop a trip, it's not going to be the same as the day before. You do two and get the same buzz. And then you end up doing three or four at a time. Silly".

"I've noticed that I had the same feeling each time but I've noticed that it's taken me longer to get that feeling. So I guess that you need to take more".
3. **SAFE USE**

Once the quality and quantity of drug intake has been established, the recreational user can address the mental and physical constraints which illegal drugs impose.

3.1 **Mental Health Risk**

There is no doubt that the possible mental health risks of drug use, especially involving physco-stimulants or hallinogenics, are recognised by the subject sample. LSD is the drug with the greatest reputation for compromising mental health and a number of our respondents spoke about “acid casualties”.

“Oh Jesus, I don’t want to get to that sort of stage where I’m so paranoid about everything and everything that people are doing”.

“I know a couple of acid casualties who are in institutions. I know about three of them, but I’ve only known them more recently when they’ve been a bit fucked up anyway. But then there was a friend of mine in Portsmouth who was ....he started having these visualisations that he was murdering his girlfriend and his parents had him sectionalised or whatever”.

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"You've got to be rational about it in order to actually take them and take them sensibly. And if you see a friend who's depressed who's taking them for the depression - and I saw this going on with a friend of mine, and for a long time - luckily it was OK in the end - but I've seen other people it hasn't been OK with....”.

3.2 Physical Risks

Although a somewhat devil-may-care attitude prevails as an undercurrent in much of the typescript, the subject sample were neither unaware nor unconcerned regarding health issues. Some reported measures are preventative (such as drinking water to avoid dehydration) others are reactive such as abstinence prompted by drug related discomfort.

"I always make sure that I take the right stuff like enough water, and take enough vitamins and stuff. But it only lasts a few hours. So it's not as if it was doing me long-term damage”.

"I don't tend to take drugs willy-nilly. I have taken just about everything in my life. At the moment I tend to use soft drugs on the basis that I'm attempting to regain my health. But I have used hard drugs over long periods of time. Such as heroin, cocaine, crack, ice. All of those drugs have actually resulted in very negative things for me and have actually attacked my health”.
“My friend. No. he just had very bad trouble with his stomach and it was from the drugs he’d been taking. Well they said don’t take anything again”. “He is a very good friend of ours. It’s good in a way as it’s stopped him doing it. It just seems if everyone’s going out and doing it, he probably feels a bit bad that he’s not joining in on it”.

3.3 Safety Zones

Adverse emotional drug reactions can range from the mildly unpleasant to the terrifying. From these experiences a tribal wisdom has accrued in dealing with unwanted effects in self and others. Reassurance, companionship and isolation away from crowded or stimulating environments appear to be the chief components of this type of management.

“If I was given a drug and it was supposed to be an E and I thought this is not an E and started feeling weird, I’d probably just go home and try and fall asleep”.

“Well, I, just myself, I try and be as affectionate and as sensible as possible. If they want anything then you try and give it to them. If they ask for fourteen avocados sliced and vinaigrette, then just go and do it”.

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"You get them into an environment where they feel safe, with people that they trust, friends or people who they know and you just keep saying to them and you keep telling them - it's not you, you're not going mad, there aren't people about to come to get you, you're on a trip, you're on acid, you're having a bad one. But you'll come down - you've taken it like four hours ago and you'll be coming down in a couple of, like three or four hours, and we'll be here for that time. We're fine, don't worry about it".

3.4 The process of drug experimentation and the establishment of recreational patterns of use is not without its risks. Sometimes these can be dramatic and the user has to discriminate between milder effects when the appropriate action is to lie down and chill out and more dramatic and possibly life threatening reactions when the appropriate course is to seek hospitalisation. On more than one occasion the interview data reveal a reluctance to seek medical advice because of the anticipated negative response of hospital staff. This antipathy may have important implications. In a recent government anti-drug television commercial (United Kingdom, 1993) the friends who have brought an overdose victim to the hospital emergency room are chastised by emergency staff rather than praised for seeking treatment for their friend. In a previous excerpt (see above) one respondent suggests that it is dangerous to seek help from the St. Johns Ambulance Brigade because they will
take you straight to the Police. These messages may deter individuals from seeking hospital treatment in cases of emergency and could potentially lead to fatalities.

"Hospitals aren't that bad, 'cost I went after some mushrooms and the doctors were all right, they just sort of said most drugs are all right in moderation, just completely fine about the whole thing".

"If I was really bad then I'd go up the hospital. I mean, like anyone would". "To a point, I mean, you can't really do that. That's frowned upon, isn't it? Like O.D.s and stuff up at the hospital, they're not really cared for are they? So it's really hard to go and get help, 'cos they just think, automatically like, you're a waster, you're doing drugs. Or because, they're up where they are and unfortunately, we're where we are". "Yeah, that's right, you know. 'Cos there's a few who do care, you know what I mean, a few do care". "But only a few". "Yeah, I know".

"I went home and I was just a bit depressed really. I just blew it into far bigger proportions than I've ever had to deal. I just knew it was the acid. So I went to bed really. Couldn't sleep but I went to bed".

"I had like three cartons of orange juice and was drinking and drinking, trying to bring myself down but it was OK when I saw
other people. But it scared me a lot”. “Who told you that orange
time, you know, it’s making
you throw up, then I’d be straight on the phone to an ambulance.
If it’s making me have fits or, obviously, ‘cos they probably deal
with that a lot, they’d know how to take care of you”.

juice might help”? “I went with some friends. They brought
orange juice to help me come down at the end. It was a mad
thought”. “Yeah, vitamin C, that’ll help me”.

“If you’re having a nasty time physically, you know, it’s making

C. VALUES AND BELIEFS

1) Positive Peer Pressure

1.1 Peer Control
1.2 Social and Anti-social drugs
1.3 Anti-alcohol

2) Taboos

2.1 Looking ridiculous
2.2 Intravenous use
2.3 Age

3) Contextual Choices

3.1 Where to do what
C. VALUES AND BELIEFS

The culture which surrounds the recreational use of drugs has evolved as a homeostatic mechanism which acts towards the preservation and integrity both of the individual and the group. These parameters seek to reduce behaviours which are unacceptable not so much by virtue of their dangerousness but because of the threat which they impose on continuing group cohesion. Someone whose drug use is sliding out of control, for example, is not much fun to be with while the specific anti-alcohol message presumably arises out of a desire to avoid the physical violence which often accompanies intoxication.

In this sense the recreational drug using peer group is no different from other social groups which seek to promote their own identity and values and thereby strengthen group cohesion and reduce internal friction. The peer group does this in a number of ways.

1. POSITIVE PEER PRESSURE

The role of the peer group and peer environment in initiating first drug experiences is well documented (see, for example, the comprehensive review of this literature in Orford, 1985). This form of peer pressure is usually seen as negative and potential drug users are exhorted to “just say no” and use the social skills of assertiveness and self empowerment to
overcome these influences. There is, however, a positive aspect to peer pressure which tends towards control and moderation.

1.1 Peer Control

Individuals within the peer group have a duty to other individuals which appears to be reciprocal. Group members should be alerted to their excessive or inappropriate use. In this way each becomes the guardian of the other. This monitoring role becomes more important in the light of the observation (see above) that it may often be easier to observe lapses of control in others than in ourselves. These extracts from the original typescript illustrate the effectiveness of this peer group monitoring function.

"It was just the fact that they cared enough to worry about me. It dawned on me and I thought, yeah well, that's fair enough. And there was a point where I'd meet them and they'd say, oh no, he's off his head. And I thought it's not really fair - it's just the fairness isn't it - it's not fair to meet people and, like, I'd think, excellent, I'm going to do four acid and meet so and so. And they'd be like, no, like, what're you doing that for? Then it sinks in, doesn't it? And you think I'm going to stop":

"Do you think you're in control of your drug use"? "Um, I don't think I would be if I didn't have the friends that I do. Sort of saying, hold on, you want to take acid again, you only took it last week - come on, get a grip. In that way, because people around me are sensible as I hope I would be if they were doing too much, yeah, I think I am. But I can see myself going
completely overboard if there weren’t the people to say, you know, come on don’t do it too often. I think”.

“It was actually two of my friends who turned to me at separate times and said, look, we’ve noticed that when you’re not taking Es you get really bad moods. And it’s that that had me realise how it sort of changes you a bit - you fall in love with it a little bit - a sort of honeymoon period, whatever, however you want to look at it. That’s what made me stop taking it”.

“If somebody’s been speeding every night for the last two weeks then you think, well hold on, that’s a bit off. You know. You keep an eye on them to see if they carry on doing it. You talk to other people …do you think they’re doing it too often? I reckon. Then you say to them very gently “What if we go out without you taking god knows how many grammes of speed? Yeah, you have to do that”.

“I know people who I’ve thought they’re doing it too often. And, but then, you sort of have to tell them because once you get onto a cycle of thinking Oh god I can’t go without taking this much speed or this much - I can’t have a good time unless I take this amount of drugs - you kind of get onto a cycle of it. Then you actually calm down a bit”.

1.2 Social and Anti-Social Drugs
There is little doubt that some drug types have a particularly bad reputation, probably because of their perceived potential for addiction. Of the 16 subjects from the original sample who made spontaneous reference to drugs they would never use, 14 (87%) mentioned heroin, 4 (25%) mentioned cocaine and 4 (25%) mentioned crack cocaine. Notably, the words used to describe these drugs and their users evoke a sense of unattractiveness more than dangerousness.

“Why wouldn’t you try heroin”? “Well, I did accidentally once. I don’t see that it’s ...well, yeah it is cultural pressure. Even amongst my drug taking friends, heroin is sort of no-no. So that’s got to be the main reason why. Maybe if it was more acceptable among my peer group, then I would”.

“Are there any drugs that you wouldn’t touch”? “Heroin, cocaine ...sad drugs, sad drugs. Because they’re down, they’re dirty drugs”.

“Hallucinogenic drugs are not sociable because it takes you off on your own trip. I like lager, because like, you drink it in pubs. Or you get take-outs with your mates. I like cigarettes because you flash the ash. And I like E because it makes you feel warm and friendly to those around you. So, there’d be no point doing it on your own”.

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1.3 Anti-Alcohol

While some of the survey sample spoke enthusiastically about alcohol consumption either in isolation or in combination with other drugs, there was a significant anti-alcohol sentiment expressed by other peer group members. Quite simply, alcohol and violence seem to be inextricably linked in the minds of these respondents and violence appears not to be a highly valued behaviour in the recreational drug using peer group. It is possible that a similar peer group who had chosen alcohol as their drug of preference would hold a macho potential for violence or “being able to look after yourself” in high esteem. Doubtless, our interview subjects took the opportunity to highlight the hypocritical inconsistency implied in society’s widespread acceptance of a drug whose potential for devastating abuse has been adequately demonstrated in preference of their chosen drugs of choice whose dangerousness might be more difficult to demonstrate.

“No, I’ve met a lot of people during my life who were alcoholics. They’re the worst sort they’re the worst. Like you can put up with E heads to an extent but piss heads really do get on your nerves and you just don’t want to associate yourself with them. They stink, they talk rubbish, they smash bars up, you know. Pick fights with you. It’s got to be the worst one to be”.

“The amount of people that actually admit to being abused because somebody was pissed due to an excess of alcohol is probably about one
percent of what reality is. And if, you know, if you have a smoke you don’t
go around hitting people. That’d be the last thing you’d do”.

“It’s like if ever I’ve gone out and there’s been trouble it’s always been
someone that’s pissed. I never get hassle off drug people”.

“Oh, Yeah, drink’s expensive for what it is really. And the effects you get
out of it ...rowdiness, getting into trouble, you know what I mean”.

“I think that drink is more dangerous than acid or speed or whatever,
spliff, I mean you loose your control. After a couple of pints you loose
your control, with drugs you don’t”.

“Actually the worst I’ve ever seen anybody was actually on poppers. I
mean it was on poppers on top of alcohol. I think I’ve seen people much
worse on alcohol than I ever have on drugs. People tend to let themselves
go more on alcohol. Because it’s more acceptable to”.

“The only time I’ve ever seen anyone even vaguely flip out is when they’ve
been having too much alcohol rather than any narcotics. So if they’re sort
of like on acid, then I’ve never seen anyone even vaguely flip out. Same as
on speed. It’s when they start drinking heavily, that is when they either
start becoming obnoxious or they start falling around doing things they’ll
regret the next day. I’ve never seen anyone get even remotely out of order
on narcotics alone”.
2. TABOOS

Associated with loss of control and anti-social activities which damage the integrity of the peer group, are various taboos which if ignored threaten the credibility of individuals.

2.1 Looking Ridiculous

People do not often want to make fools of themselves and, when they do, usually regret it afterwards. These incidents are observed and subsequently avoided by other members of the group. Looking ridiculous is another aspect of loss of control which lowers the status of individuals in the eyes of their peers.

"You don’t have to take certain drugs to find out what they’re like. I mean you can look at the people. You know that piss heads look pathetic. So you try and avoid becoming a piss head".

"Friends of mine just go overboard and take lots of different drugs all at the same time. Pass out and collapse and all sorts of things. And they expect their friends to pick them up and look after them, which is not on really. Ridiculous".

"He was fucking getting out mirrors and laying them out on the surface in the kitchen whilst everybody else was drinking tea. And I just thought
"...he seemed so much to want somebody else to get involved to make him feel good about it.

"The gutter scenario, they're a long way from that. And I don't think they'd let that happen. It's just not classy".

"Especially even on alcohol, but with drugs mixed in as well, you remember perhaps an hour of eight hours. You can remember absolutely nothing at all. Somebody will say to you, hey, last night in the Gloucester night-club you were sitting there with a large erection and you were pulling yourself off, gagging over some woman who was sitting next to you. Now, you hear that and you think, shit, you think it can't be possible".

"No, I don't want to do that again. I think I made that much of an arse of myself that I didn't want to do that again in case I made another complete arse of myself".

"When you're first taking everything's brilliant and you're into sticking vicks up your nose because everything's meant to be that much better when you're on an E. And it started getting stupid. People going around with dummies in their mouth. Pots of vick on a chain round their neck. O God, it's really sad".
2.2 Intravenous Use

There is a welcome and reassuring taboo about drug administration by injection. It may be that the powerful anti-IV propaganda which has surrounded the AIDS/HIV publicity over the last decade has fuelled a healthy disregard for needles and syringes. It is also possible that injection itself is seen as a low status activity since it is associated with low status drugs (Chiefly heroin and to a certain extent cocaine). The combination of these factors has resulted in a welcome ground swell of anti-injection indoctrination.

"There's no point in sticking a needle in your arm and getting smacked out and being numb for the rest of the night, 'cos that's not me at all. I'm a pretty hyperactive person. I don't want to stand in the corner off my nut".

"I think the moment you decide to shoot drugs up then you're looking at a totally different situation. I think so anyway. I think then it takes on a completely different angle as far as drug taking goes. If you're prepared to go to those lengths to take the drug, prepared to abuse your body to that extent, then you're obviously in a very serious situation. I've never done that".

"I wouldn't inject anything. Whatever it was, I would not inject. Through a completely girly fear of needles. I think attitudes to drugs generally
have changed because hard drugs used to be injected. A heroin addict ....it was all about needles”.

2.3 Age

Textbooks refer to the process of “maturing out” from a drug using career. The age distribution of our survey sample demonstrates the youthful nature of recreational illicit drug use. The comments on age and its relationship to drug use would appear to indicate that some recreational users would expect to become more and more selective as they become older, either abandoning the use of illegal drugs altogether or sticking to mellower drugs like cannabis and abandoning the use of hallucinogenic and psycho-stimulants.

“So many of my peer group takes drugs at the moment. I doubt if they’re all going to be stopping when they hit sort of twenty-five or thirty. I’d have thought that the drug use is probably going to become more prolific in other age groups. Although having said that, I mean drugs have been taken for centuries and centuries and it does seem to be a tendency that people stop taking them the older they get. They find other things of interest. They find that drugs are too much of a hindrance to getting on and doing whatever else”.

“But when I was about eighteen I said, right, when I’m twenty-three I’ll sort it all out then. I’ll carry on having a laugh till then. But I’m twenty-
three now and I'm just going to go on having a laugh until I'm thirty. And at thirty, I'll just make up another age”.

“I just see myself mellowing down. Less speed. Less trips, 'cost they make you go a bit off your rocker”.

“I think as I get older I'll just concentrate more on mellower stuff. Stuff like smoking hash. There're no horrible side effects, no come down, no addictions”.

3. CONTEXTUAL CHOICES

Much of the material presented suggests that the use of recreational drugs is more purposeful than haphazard. As well as making informed choices about types, quantities and methods of administration, the peer group chooses environments and contexts to match the drugs they take. Some drugs are matched to pubs and clubs, others to isolated introspection and others to pleasant country-side walks. Drug types become matched with contexts by experiential and observational learning and occasionally by advice from the dealer who sells them to the user.

“I dunno, but as you get older, you know what drugs for what situation. It's like you don't want to take five acid tabs and walk into a wedding ceremony or something or even a really hectic house party. Best thing to do is go out and find yourself some head space. It sounds a bit strange but
communication with too many people when you’re in that state isn’t good for you. Out in the countryside in the summer is nice”.

“You wouldn’t just take it when you were sitting in your house. You only do it to socialise with other people. To be on the same level as the other people that are in that club. ‘Cos you know near enough all those people are going to be taking that”.

“Some people can’t handle pubs when they’re tripping. I can’t if it’s too strong. But if you take half a trip, you can go out clubbing. But if you take a whole one, sometimes you just want to sit in until it’s peaked and it’s mellowing out a bit, before you can handle facing loads of people. It’s best among really good company, people you know really well”.

“I would never take speed just sitting around. I’d only take that if I was going out. So, yeah, it depends on the situation you’re in”.

“Living in a small town, the drug culture is very small so you know you’re going to stick out like a sore thumb. You’re very worried about the local constabulary. And eight of you going into a small pub, sitting in a snug bar if you’re off your head on acid is not done - not done”.

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TABLE 10

D EXTERNAL CONTROLLING FACTORS

1) Financial Control

2) Availability

3) Legislation

4) Employment
D EXTERNAL CONTROLLING FACTORS

The controlling factors which this paper has addressed thus far are generated largely by the individual or by the peer group to which he or she belongs. There are, however, external controlling factors which have little or nothing to do with the values, beliefs and boundaries generated by the user group. These factors exist in the real world outside the peer group and have direct impact on the type and extent of drug use.

1. Financial Control

Unsurprisingly, recreational drug use is largely dependent on disposable income. Once again, important characteristics of recreational drug use emerge. Firstly there is little evidence that necessities are sacrificed in favour of drug purchase. Secondly, there is a useful comparison to be made between recreational and dependent drug use. While recreational drug use is controlled by disposable income, dependent drug use is more likely to be funded by acquisitional crime or other illegal means and therefore bears little relationship to legitimate income.

"I’d like to try coke sometime. But I’ve heard that’s really not all it’s cracked up to be either. But at fifty quid a gramme it’s just out of my price range. So I’ll wait until one day I’m feeling particularly well off".

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"I don't leave myself short with buying drugs if you know what I mean ... I always make sure I've got enough for everything else and if I can't afford them, I don't get them and that's that".

"Money is one of the main guiding factors and if he had all the money in the world, he'd be able to give up his job and he wouldn't have that one to worry about. So I'd be somewhat concerned if he had all the money in the world".

"He hasn't got any cash mainly. It tends to be circumstantial and I think he's got a number of other things in his life. Sort of, when he runs out of money, he runs out of drugs".

"I was actually taking a lot of ecstasy, but it's so expensive. I had a bad time once and it's cheaper to get acid. I get a much stronger effect from it anyway. Money has controlled what I take".

"Hash is quite cheap. So that's not much of a problem. Speed - we have to do that when we've got our dole cheque in".

"Um, I smoke hash, and I take speed and E's when I can afford them and acid and that's it, 'cause I can't afford anything else".
2. Availability

The close correlation between availability and extent of use is widely accepted. It is at the centre of the supply side reduction policy and it is accepted as common sense that no-one can use a drug that isn’t there. The references to availability in this study would suggest that the quantity and quality of drugs available on the street is increasing. In the absence of successful supply side interventions, the importance of demand side management, a concept which includes successful recreational use, must be emphasised.

“I’ve noticed that more and more people are taking cocaine. It’s more available, it’s there. And it was much harder to get three or four years ago. And having good cocaine, that was something that only happened at very special do’s”.

“When I first had my first hard drug experience, it kind of petered out for a while and then as various pressures presented themselves, drugs became more accessible. I began to take more and more drugs on the basis that they were there”.

“I don’t take ecstasy any more, although ....no so much anyway. Maybe every three or four months. I take an awful lot of speed. But that again goes in spates of how often I can get it”.
3. **Legislation**

Inspection of the raw material on which this study is based does not reveal much deterrent effect in anti-drug legislation. While the penalties associated with drug dealing may have deterred a number of people from this activity, little concern is expressed about the possible consequences of consumption or possession of illegal substances. A surprising level of familiarity with the drug categories and classes contained in the 1979 Misuse of Drugs Act was demonstrated by several subjects in the study but this technical knowledge appeared to have little or no impact on their behaviour. The cautionary tales of police courts and prison sentences seem always to warn against dealing and never to warn against using.

"I'm a scaredy cat. Simple as that. I wouldn't put myself into a position where I could get into too much trouble over something that I see isn't worth getting into that much trouble over. Small time dealing - in the sense of getting stuff for other people".

"I know someone who got caught with about seventy-two E's about three months ago and he's still trying to pay that debt off, because he had them all confiscated - you know, seven hundred quid. So it's a bit risky as well as him having to go to court. I mean, he may get off that or he may not".
4. Employment

The requirements and expectations which employment impose on the individuals who had been working provided another external constraint. For these people, demands of the job had been a priority and had resulted in planned periods of abstinence so as not to impair their performance. The extracts below reveal a level-headed pragmatism and sense of competing priorities which, arguably, is missing or severely compromised in dependent drug use. Once again a boundary marker between recreational and dependent use emerges. When drug use and employment become incompatible, the recreational user modifies his or her drug use, the dependent user modifies his or her employment.

"I've got to work. And so to work, that brings you down to a reality anyway. You just think, oh shit, I've got to work, which is like horrible really. That's what it is. It's priorities. Realising you've got to survive".

"I can't afford to do it very often. And I think it's very much a situation drug. So if I'm in the situation at a club with a possy on for a good time with no commitments on the next day, then yes. But that's not every day".

"You have to do something productive and it's difficult to do anything productive when you take too many drugs".
"I was working for a bit and that stopped me, because I knew I'd feel like shit in the morning. It was quite a responsible job and so I didn't think I'd take too much then".

Discussion

This research has attempted to draw together the practices, beliefs, rituals and sanctions which combine to produce the phenomenon of controlled recreational drug use. The research tool used was intentionally non-directive allowing the priorities and concerns of the respondents to emerge rather than those of the researcher. The subjects in this survey spoke a great deal about their drug use and very little about themselves. As a result it has been possible to make a detailed survey of the external and internal boundaries which maintain the controlled use of drugs but it has been difficult to say very much about the people involved. Few if any problematic drug users embarked on their drug career with the specific intention of losing control or becoming addicted. To use the analogy of road safety, it is as if we have documented the meaning of road signs such as speed limits, one way systems and dangerous bends. We have not identified the differences between the safe drivers who observe these warnings and the unsafe drivers who do not. To extend the analogy, however, the discovery of systems which promote safe road use and road users who, by and large, adhere to these systems, calls into question the "don't drive" message which is analogous to the "just say no" message promoted by the zero tolerance lobby. In his influential work, Zinberg
(1984) states on several occasions that the sanctions and rituals surrounding alcohol use are not there to encourage use but to discourage abuse. The data which this study generated would suggest that similar rituals and constraints operate within the illegal drug culture but, for obvious reasons, in a more clandestine way.

Despite the close connection made between drug use and addiction, it is reassuring to identify a set of controlling influences, checks and balances within the social structure which surrounds recreational drug use.

We already have clear indications that in terms of maintaining control, there is what might be called a "hierarchy of dangerousness". When we look at the specific drugs described by the controlled users, it is clear that some are protective of and some antagonistic to recreational use. The protective group of drugs are distinguished by the fact that their effects, their low prices and their context of social use seem to enable the users to remain in control without becoming casualties. By contrast the antagonistic group of drugs appear to create problems: high prices lead to financial difficulties, the context of their use points towards isolation and dislocation from the social group; and their effects create mental and physical dependence.

This being so, it is perhaps not surprising that information campaigns which focus on drugs in an undifferentiated manner have not proved successful. Those which have highlighted a specific risk (for example, the spread of HIV from injecting drugs) are far more effective. It would seem that in
future, campaigns should acknowledge that not all drugs are the same, not all drugs carry the same risks. Experience of locally-based information initiatives such as the series of FACTLINE campaigns in Brighton, England (1991) illustrate the principle of emphasising very specific risks to a very specifically targeted audience. This type of work can effectively build upon the control influences and boundaries already known to that audience and can reinforce existing knowledge and experience within the user's social group: a very important factor.

The area of peer training in drugs education has received, deservedly, a high level of interest nationally. The peer coalition work of McDermott et al, (1995) has already been mentioned. It is a compelling argument that if, as this research shows, the greatest credence and influence derives from peer messages - especially those offered on the basis of experience - this resource should be mobilised and exploited in the campaign to reduce drug related harm. The essential (and sometimes missing) ingredient is that the peer trainers should have a compatible knowledge and experiential base. Simply being of an equivalent age may be necessary, but is certainly not sufficient. Imaginative examples of this rule of thumb have been implemented. McDermott (1993b) advocates the use of "indigenous workers" in reaching out to high risk drug users to progress HIV prevention. These people would be ex- or even current users recruited because of their ability to infiltrate and influence user networks in a way that the non-users (professional or volunteer) could not.
Hanslope (1994) recruited sex workers in Liverpool to train them in legal aspects of prostitution, safer sex and injecting practices, physical health and "tricks of the trade". These women were then supported in passing on this knowledge of other sex workers with whom they came into contact. The evaluation of this project proved it to be "an even greater success than was hoped". The self esteem of the recruited trainers was elevated and the harm reduction message passed on effectively at street level.

There are further implications for information and education strategies, which are currently constrained by the unwillingness of most agencies in Britain to provide information about controlled use. The contrast between advice about alcohol use and advice about the use of illegal drugs is striking; in the case of alcohol, advice is widely available demonstrating the limits and boundaries of controlled use. Where illegal drugs are concerned there is an apparent barrier to giving this kind of information at an appropriate age, either in the context of primary prevention or at the stage of early intervention, for example with young experimental users.

This barrier exists despite evidence that such intervention can reduce the dangers faced by young users.

The parallel situation can be seen in material for parents of teenagers; many of the messages in recent campaigns have presented all drugs as fear objects. A more helpful and realistic approach would educate about
relative risks and this would create more validity for the accompanying advice which can be broadly summarised as “don’t panic”.

A greater focus on elements of control also has an impact on the ways in which health initiatives are delivered. In order to build on the protective control values within recreational drug use, the emphasis should be on new ways of providing outreach services to further develop the positive factors operating in the social context.

In terms of treatment strategies, a change in emphasis would be required in order to implement services driven by a similar philosophy. Rather than being either abstinence or maintenance oriented, the key concept would be re-establishment of control. This could be available, for example, as a short-term intervention to help people who become aware of a loss of control during a period of recreational drug use. The goal of such an intervention would be for the individual to regain control by building upon clearly identified protective factors - which we could perhaps term “control counselling”.

There will, of course, still be a need for some services for users of antagonistic drugs (eg the opiates or crack cocaine) for whom other treatment models would still be the first choice. Apart from the direct benefits to service users derived from the differentiation of drug treatments proposed here, a second benefit would be to broaden the perception of
treatment services held by the wider community, away from the narrow “addiction” stereotype and towards a less marginalised view.

As acknowledged earlier in this paper, this research has the limitations imposed by the small subject sample and by the method of open-ended data-gathering, which has resulted in some incomplete data-sets. Despite these limitations, the work has the strength of being driven by the perceptions of the subjects and they have generated some important constructs. Notwithstanding the ad hoc nature of this investigation, these findings would seem to support the earlier findings of Zinberg (1984) and Powell (1973). As in earlier work, a cohort of successful recreational drug users has been described which challenges the accepted view of addiction as a necessary effect of illicit drug use. On this basis, a series of proposals are suggested which may inform future strategies in the areas of education, information campaigns and service provision.

Further research should attempt to address the variables and influences which differentiate controlled drug users from dependent drug users who are, after all, unsuccessful controlled users.
In the second part of this research (Really Useful Knowledge Part II), some of the core values, beliefs and behaviours which emerged from this study are presented in questionnaire form. This questionnaire will be used to test for significant differences in response patterns in a group of recreational users and a comparison group of drug clinic attenders whose use has become problematic.
REALLY USEFUL KNOWLEDGE:

A COMPARISON BETWEEN RECREATIONAL DRUG USERS AND DRUG SERVICE USERS

Research component for Psych D. in Clinical Psychology

University of Surrey 1995

PART II
1. **INTRODUCTION**

In the first section of this research, the technique of social ethnography has been used to generate a framework within which successful recreational drug use probably exists. The value of these rich data is somewhat restricted by the small sample size and the non-directive interview technique. As discussed earlier, this has led to incomplete data sets and a comparative lack of "hard data" for statistical analysis.

In the second part of this research, some of the main features of this framework for successful recreational drug use will be tested on a larger sample using quantitative research methods. It is also intended to compare a recreational drug-using cohort with a similar sample of clinic attenders, that is drug users whose problems (of one kind or another) have brought them into contact with a drug advise and treatment agency. The former group, by and large, may be described as successful recreational users, while the latter are by and large unsuccessful users who have had cause to approach a helping agency. The data reviewed in Part I of this Research project would suggest a socially integrated, cautious, fun-loving and controlled profile for recreational drug users while the expected profile of the clinic group with "drug problems" is more likely to be isolated, problematic, uncontrolled, impulsive and socially marginalised. This study does not involve the manipulation of any of the experimental variables other than an attempt to match the
two samples for age and gender. A questionnaire was developed to attempt to discriminate in whole or in part between the two subject groups.

2. METHOD

2.1 The development of the questionnaire

The Really Useful Knowledge Questionnaire arises directly out of the data gathered in the first part of this research study. The questionnaire (see Appendix I) was piloted on 20 recreational users. This process led to some minor modifications being effected mainly because a small number of items were either ambiguous or misconstrued. At the suggestion of the research interviewers the wording of some items was changed in flavour rather than in essence. On item 3.9, for example, "I use drugs to protect myself from people" was altered to "most of my drug use is to be in my own world". "I use drugs to get closer to people" was changed to "most of my drug use is to be part of a group".

In some questions the meaning intended was made clearer in the re-draft. Item 3.7, for example, was changed from "in general do you feel in control of your drug use"? to "In general do you feel in control your drug use at present"? In section 3.1, the question "which drugs have you used in the last four weeks including alcohol"? was altered to "which drugs have you used in the last
three months including alcohol”? This was because many of the respondents in the pilot groups used drugs such as LSD, Ecstasy or Amphetamine on a regular but infrequent basis - sometimes less frequently than once a month. The original wording of the question would therefore have excluded some potentially valuable data on infrequent recreational use. It was decided that any drug used less frequently than once in three months would fall outside the criteria of recreational use.

The modified questionnaire (Appendix II) with the modifications mentioned above was developed in February 1995 for use with the comparison samples of treatment and recreational populations. Because of the limitations of time and access imposed on this research study, the attempt to match the samples has not been as exhaustive as one would prefer. First, the experimental criterion dictated that all respondents should be aged 30 years or under to avoid the predicted problem of comparing a younger recreational sample with an older treatment sample. Second, every reasonable effort has been made to create an equal gender balance within both samples. This was difficult in the treatment population because agencies throughout the United Kingdom tend to attract males in significantly greater numbers than females (Measham et al, 1994). The final version of the questionnaire is now examined in some detail, broken down into its six component sections.
2.2 Really Useful Knowledge Questionnaire - Construction

Section 1 A Few Personal Details

1.1 What is your age?

1.2 What is your gender?

1.3 Are you currently:  a) employed....................(  )
                      b) unemployed...................(  )
                      c) a student.....................(  )
                      d) employed in the home....(  )

To preserve the anonymity of potentially sensitive information, respondents were not asked for any personal details other than their age and gender. These items were included to provide some basis for matching the recreational and treatment samples and also to examine for covariance of other variables with age and/or sex.

Employment status (1.3) is included to investigate whether recreational users are more likely to have a wider behavioural repertoire and access to broader societal influences in comparison to a treatment population who, whether as a cause or effect of their problematic drug use, are less likely to be in employment or education. In the first part of this research study it was observed
that employment or academic commitments represented a significant external controlling factor in recreational drug use.

Section 2  Lifestyle Choices

2.1 Do you exercise? Y/N
2.2 Do you go dancing? Y/N
2.3 Do you take part in team sports? Y/N
2.4 Do you enjoy the company of others? Y/N
2.5 In general, do you feel in control of your life? Y/N

This section is included to test the impression given by the recreational drug users that their drug use took place in a social context in which having fun and staying in control were highly valued attributes and alternative recreational pastimes were available and often chosen in preference. In the typescripts of the recreational sample interviews, a variety of sporting activities are mentioned as competing alternatives.

Section 3  Drug Choices (including alcohol)

3.1 Which drugs have you used in the last 3 months including alcohol _____
3.2 At what age did you first use an illegal drug other than alcohol? _____ yrs
3.3 Which was the first illegal drug that you used? _____
3.4 Is your drug and alcohol use controlled by your income? Y/N

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3.5 Do worries about breaking the law reduce your use of drugs? Y/N

3.6 Do you think you will still be using drugs in the same way 10 years from now? Y/N

3.7 In general do you feel in control of your drug use at present? Y/N

3.8 Have you ever approached a drug agency for help in regaining control over your drug use? Y/N

3.9 Mark where you feel you are on the following scales:

Most of my drug use is to:

be in my own world 0 1 2 3 4 5 6 7 be part of a group

3.10 I feel alcohol is:

a social drug 0 1 2 3 4 5 6 7 an anti-social drug

3.11 How much of your available income do you spend on drugs or alcohol?

some ( )
most ( )
all ( )

3.12 Has your drug use ever got you in trouble with (tick all that apply)

the law ( )
pARENTS/FAMILY ( )
sCHOOLS/COLLEGE ( )
work ( )
fRIENDS ( )

In this section the initial questions (3.1, 3.2 and 3.3) are intended to give a brief account of drug use as well as type and age of initial illicit drug experimentation. Research comparing problematic drug users with non drug users (see for example Orford, 1985) suggests
that individuals who go on to have a problematic relationship with substances start to use those substances at an earlier age than those whose use discontinues at the experimental stage. These observations include and refer particularly to smoking and drinking as well as illegal drugs. The recreational sample (see part 1 table 3) were most likely to have tried Cannabis first. Question 3.3 was included to ascertain whether the choice of first illegal drug discriminated between a recreational and treatment sample.

Question 3.4 investigates once again the importance of external controlling factors. Anecdotally, individuals with drug or alcohol problems will always “find a way” to fund their use by fair means or foul. A treatment sample in which intake control has been compromised may not apply similar boundaries to the acquisition of substances, as a recreational sample using smaller doses of “pocket money” drugs.

Behavioural boundaries around law breaking are tested in a similar way in question 3.5. Question 3.6 is included to investigate the observation made by some respondents that recreational drug use was a youthful activity which they fully expected to have modified or abandoned in later years. Anecdotal evidence from the treatment sample, on the other hand, might suggest that drug use and drug dependency are accepted as an inevitable part of their lives or behavioural repertoire and that they expect and envisage little change in the future.
Question 3.7 raises once again the issue of control whilst question 3.8 provides a further check as to which sample (recreational or treatment) the respondent belongs within. Individuals answering Yes to question 3.8 are excluded from the recreational sample as are individuals (question 3.1) who have not used any illicit drugs within the three months prior to completing the questionnaire.

Question 3.9 revisits the social context in which drug use takes place to examine which is favoured by the user, and to investigate the isolation/integration dimension of purposeful drug use.

Question 3.10 tests specifically the observation from part 1 of this research that alcohol was a low status, anti-social drug, the excessive use of which was discouraged by the recreational drug using peer group.

Question 3.11 investigates competing financial priorities with the expectation that the proportion of available income spent on drugs or alcohol would discriminate between a recreational drug using population and a treatment population in which drug use has become problematic.

Question 3.12 pursues the theme of problems arising out of drug use with the expectation that the treatment group will have experienced difficulties in more areas than the recreational sample. These difficulties, in isolation or combination may have resulted in
the "critical mass" which bought the individual into treatment.


Section 4 Drugs and Friends

4.1 How many of your friends are drug users? none ( ) some ( ) most ( ) all ( )

4.2 Do your friends worry about how much you use? Y/N

4.3 Do you worry about looking ridiculous when you're on drugs? Y/N

4.4 Do you worry about how much some of your friends use? Y/N

Question 4.1 investigates the extent of peer group influence and involvement in drug use. Drug careers progress logically from drug users having few to having many drug using friends and acquaintances as use escalates. Recreational (controlled) drug use also implies choice and the existence of alternative behaviours. This in time implies that a recreational user is more likely to have friends who are not involved in drugs than a problematic drug user whose choices have become limited and whose behavioural and social repertoire has narrowed.

Question 4.2, 4.3 and 4.4 investigate the concerned peer group supervisory function which recreational users reported in the earlier
part of this research project. To care and be cared about are both informal controlling mechanisms which preserve group cohesion and identify whilst discouraging the abuse of substances and abusive, dangerous or embarrassing behaviour arising from excessive consumption. Once again, the hypothesis that problematic drug use tends towards the isolation of the individual while recreational drug use arises out of, and is reinforced by a gregarious instinct, is tested by the questions in this section.
Section 5 Drugs and Knowledge

5.1 Did you find out about the drugs you have used before using them? Y/N

5.2 Where does your most important knowledge about drugs come from? (Rank in order of importance)

6 = most important
1 = least important

own drug experience ( )
TV newspapers, radio etc ( )
parents ( )
school ( )
drug information leaflets ( )
friends or others’ drug experience ( )

5.3 What drugs would you never use? _______

Section 5 returns to one of the central themes of this research project - a comparison of different sources of drug related knowledge. Part I of “Really Useful Knowledge” suggested that first hand experience was more valued by drug users than channels of formal education or information. Observational or anecdotal information from friends and acquaintances followed as a close second. Much parental, educational and media information and advice was dismissed by recreational users out of hand.

Question 5.1 investigates the level of caution applied by experimental (first-time) drug users to the objects of the experimentation. One method of risk reduction identified in Part I
was the practice of researching a specific drug type before use as a form of preparation. It is possible that failure to apply this form of precaution may be an indication of the recklessness and impulsivity which characterises later problematic drug use. It may therefore be the case that while successful recreational users are more likely to find out before trying, unsuccessful recreational users (who become the treatment sample), are more likely to find out by trying.

Question 5.2 invites respondents to rank their sources of knowledge in order of perceived importance. This question is included to support or refute the observations addressed in Part I concerning sources of drug information and their relative values.

Question 5.3 explores the self-imposed boundaries in relation to the use of different drug types, classes and methods of administration.

Part I (table 5) lists the various drug taboos reported by the recreational sample. Heroin was the drug most frequently mentioned as one which would “never be taken”. Unsurprisingly, therefore, both Heroin and Methadone appear low on the frequency of use table (Table 1), as do Crack Cocaine, Amyl Nitrite and Benzodiazepines.

The difference between successful and unsuccessful drug use lies largely in the development and observation of safe boundaries. The avoidance of drugs “antagonistic” to recreational use and the
selection of those “protective” of recreational use may be one of the most important boundaries of this type. It might therefore be expected that the recreational sample are more likely to report avoidance of “antagonistic drugs” (Heroin, other opiates, Crack Cocaine and minor tranquillisers) than the “treatment” sample whose use of antagonistic drugs may partially account for their loss of control and subsequent “treatment” status.

Section 6 Drugs and Trouble

6.1 Is your drug use controlled by the fear of physical problems?

not at all 0   1   2   3   4   5   6   7 entirely

6.2 Is your drug use controlled by the fear of mental problems?

not at all 0   1   2   3   4   5   6   7 entirely

6.3 To what extent do you think you have learned by the mistakes you or your friends have made?

not at all 0   1   2   3   4   5   6   7 a great deal

6.4 Is there anything that I’ve neglected to ask you or that you feel is important?

Section six draws on the observations reported in Part I under “Limiting Experiences” (A 1.3), and “Safe Use” (B.3). This section of the questionnaire has been developed from the ubiquitous theme
of caution and control which appears to underpin “recreational”
drug use as compared with the apparent recklessness and failure to
impose or retain control which underpins the problematic use of
drugs in the “treatment” group.

It should here be noted that there are competing theories on this
issue. The “vicious cycle” model of drug escalation and loss of
control (Beck et al, 1993, Peele, 1985), suggests that it is the
tendency to worry excessively about physical mental or social
circumstances which increases drug use, rather than these concerns
imposing a limiting effect.

However the observations of recreational users (Part I) would
suggest that self-concern is a positive pressure which promoted
control. The treatment group may be more likely to ignore
concerns for their physical or mental well-being and persist in the
potentially problematic use of drugs.

Questions 6.1 and 6.2 invite respondents to rate the extent to which
fear of negative physical or mental consequences control their drug
intake.

Question 6.3 investigates the role of learning by peer example or
experience (see Part I section A.1.3 “Limiting experiences”). It was
clear from the interviews with recreational drug users that they
acknowledged a homogeneity of experience; what didn’t work for a friend would be unlikely to work for them. One recreational user reported:

“....I asked all the people to tell me what the effects were of each drug so I would be able to deal with it...”.

another said:

“....I had a bad trip once. That was about just over a year ago and that put me off taking acid (LSD) for a long while. It was about six months before I actually took acid again and even then I only took a small quantity....”.

This ability to learn from mistakes and alter behaviour accordingly may differentiate “recreational” and “treatment” group drug users.

Question 6.4 is the final and “catch-all” item in the research questionnaire. Respondents are invited to add any comments, observations or criticisms which they find are appropriate on completion. In the event (see Results section) few took this opportunity.
2.3 DATA COLLECTION

The "Treatment" Sample

The treatment sample is made up of clients attending either the Options community drug team in Worthing, West Sussex, or the Drug Advice and Information Service (DAIS) in Brighton, East Sussex. The criteria for inclusion in the research study were as follows:

- The client must be aged 30 years or under.
- The client must be seeking help for a problem regarding their own drug use. Clients requesting information or leaflets only would not be included. Clients asking for help in connection with the problematic drug use of another (partner, friend, family members etc) would not be included.
- The client must have used drugs within the previous three months.
- The client must be willing to fill in the questionnaire, or give the information to a staff member who would fill it in.
- The client must be recently engaged in treatment. For the purposes of this research study, "recently" was defined as having less than 3 months contact with the service. This criterion was introduced to exclude from the sample clients who had been well stabilised and had a reduction in drug related problems. Stabilisation on prescribed substitute medication, for example, would reintroduce an element of control, as would the increased insight and "self-efficacy" (Miller, 1983) which successful engagement in a psychotherapeutic contract would elicit. The study, in short, was
intended to focus on the loss of control and absence of boundaries with accompanying early entrants into treatment.

- The client could have had previous discreet episodes of treatment but must be early in the current episode for the reasons stated above.

Questionnaires were administered by clients’ keyworkers at either Options or DAIS and returned to the author for collation.

The “Recreational” Sample

The data on the recreational sample were collected in Brighton, East Sussex, during the first half of 1995. Collecting these data represented a greater challenge than the “treatment” sample because the respondents were not a “captive” audience who identified themselves as drug users by approaching treatment services.

Selection was initially by the two radio journalists contacting acquaintences who were known to use drugs recreationally. Other individuals were approached “cold” some of whom did not use drugs. Acquaintances of known contacts were also used in the “snowballing” method developed by Hartnoll (1989).

Subjects were approached at home, some in local pubs, others over the telephone. Local Sunday markets and “Car Boot Sales” were used for approaching subjects “cold”. Pubs tended to deny the
researchers request to undertake the study on their premises and licensees asked the researchers to leave on two occasions when they were observed canvassing on pub premises. Subjects were also reluctant to be approached in pubs because they felt trapped and unable to refuse and move on.

3 RESULTS

A total of 68 completed questionnaires were collected for each of the recreational and treatment groups. Some questionnaires from both samples had to be rejected because the responses had been incomplete, or illegible. At the end of the data collection period, more recreational group questionnaires were available than treatment group questionnaires. Four recreational group questionnaires were therefore discarded randomly to match the sample sizes.

The data generated by the questionnaire survey are largely of nominal or ordinal level. Two questions (1.1 and 3.2) which enquire about age are of ratio level. The questionnaire data were analysed using the Statistical Package for Social Scientists (SPSS) (DOS) employing Chi square and Spearman’s rho statistics. The Chi square statistic was selected as a robust measure of association for nominal data in an independent subjects research design. In questions where the responses could be ranked (ordinal data) Spearman’s rho was used as a measure of correlation.

The data, population characteristics and research method do not fulfil the criteria for using parametric tests. The data are largely nominal or ordinal
rather than interval or ratio, and no assumption is made as to similarities in the variance of the two samples nor is it assumed that the data under investigation are normally distributed within the population. Whilst parametric tests are acknowledged to be more powerful and sensitive, the use of non parametric analysis ensures that any significant variation or correlation will be a strong effect identified by a less powerful statistical tool.

The results are presented using the same order as the questionnaire and will be dealt with section by section.

Section One A Few Personal Details

Table One sets out the age distribution of the entire sample broken down into five year age categories and recreational/treatment groups. The results demonstrate a fair degree of match. The mean age for the recreational sample is 23.7 years whilst that for the treatment sample is 24.4 years.

TABLE 1 AGE DISTRIBUTION BY GROUP

<table>
<thead>
<tr>
<th>AGE GROUP IN YEARS</th>
<th>11-15</th>
<th>16-20</th>
<th>21-25</th>
<th>26-30</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recreational</td>
<td>0</td>
<td>18</td>
<td>22</td>
<td>28</td>
<td>68</td>
</tr>
<tr>
<td>Treatment group</td>
<td>1</td>
<td>16</td>
<td>14</td>
<td>37</td>
<td>68</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>34</td>
<td>36</td>
<td>65</td>
<td>136</td>
</tr>
</tbody>
</table>
The gender match was predictably less successful. In the recreational sample 48% were male and 52% were female. However, in the treatment sample 66% were male and 34% were female. This bears out the general gender profile common to drug treatment services discussed in the introduction.

Analysis of employment status demonstrated a significant difference between the two groups (see table 2).

**TABLE 2**

<table>
<thead>
<tr>
<th></th>
<th>Employed</th>
<th>Unemployed</th>
<th>Student</th>
<th>Employed in the Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recreational</td>
<td>39</td>
<td>11</td>
<td>14</td>
<td>4</td>
</tr>
<tr>
<td>Treatment</td>
<td>19</td>
<td>36</td>
<td>7</td>
<td>6</td>
</tr>
</tbody>
</table>

Chi square = 22.92  
Significance = p < 0.01

The results indicate that employment status is significantly related to recreational or problematic drug use. The treatment group were more likely to be unemployed while the recreational group were more likely to be employed or have student status. This lends weight to the discussion (above) on external controlling factors imposing a protective effect on recreational drug use.
Section Two  Lifestyle Choices

Questions 2.1, 2.2, 2.3, and 2.4 were collapsed into an overall measure of social integration. These items combined to provide a rough and ready measure of the gregarious activity which appears to characterise recreational drug use. The results were analysed as follows:

Individuals who indicated that they liked exercise, dancing, team sports and the company of others were given full marks for integration. Individuals answering no to these four questions where given no marks for integration. Levels in-between were labelled 1, 2, and 3 markers of social integration respectively. Figure 1 gives a graphic analysis of these data by group. The analysis (Chi square) failed to support the null hypothesis. We thus reject as implausible the notion that the result arises from sampling error in a population in which the two variables are unrelated, and accept that there is a significant association between markers of social integration and the dependent variable, that is, membership of the recreational or treatment group. The Chi square value of 16.322 with four degrees of freedom gives a significance level of p < .01.

Question 2.5 asked whether respondents felt in control of their lives. 55 (81%) of the recreational sample felt that they where in control of their lives compared with 36 (53%) of the treatment sample. Chi square analysis gave a value of 11.98 with 1 degree of freedom and a significance level of .00054, giving a p < .001.
Graph Depicting The Association Between Markers of Social Integration/Functioning By Group

FIGURE 1
Section Three  Drug Choices (including alcohol)

Table 3 compares drug use reported in the last three months with group membership. The raw data show significant discrepancies between the two groups.

**TABLE 3 WHICH DRUGS HAVE YOU USED IN THE LAST MONTHS (INCLUDING ALCOHOL) BOTH GROUPS**

<table>
<thead>
<tr>
<th>TYPE OF DRUG</th>
<th>RECREATIONAL n</th>
<th></th>
<th>TREATMENT n</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Methadone</td>
<td>0</td>
<td>(0)</td>
<td>20</td>
<td>(29)</td>
</tr>
<tr>
<td>DF118</td>
<td>0</td>
<td>(0)</td>
<td>5</td>
<td>(7 )</td>
</tr>
<tr>
<td>Diconal</td>
<td>0</td>
<td>(0)</td>
<td>5</td>
<td>(7 )</td>
</tr>
<tr>
<td>Heroin</td>
<td>0</td>
<td>(0)</td>
<td>22</td>
<td>(32)</td>
</tr>
<tr>
<td>Opium</td>
<td>0</td>
<td>(0)</td>
<td>2</td>
<td>(3 )</td>
</tr>
<tr>
<td>Palfium</td>
<td>0</td>
<td>(0)</td>
<td>2</td>
<td>(3 )</td>
</tr>
<tr>
<td>Hypnotics/Benzo’s</td>
<td>0</td>
<td>(0)</td>
<td>4</td>
<td>(6 )</td>
</tr>
<tr>
<td>Alcohol</td>
<td>64</td>
<td>(94)</td>
<td>39</td>
<td>(57)</td>
</tr>
<tr>
<td>Cannabis</td>
<td>64</td>
<td>(94)</td>
<td>48</td>
<td>(71)</td>
</tr>
<tr>
<td>Barbiturates</td>
<td>0</td>
<td>(0)</td>
<td>1</td>
<td>(1 )</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>29</td>
<td>(43)</td>
<td>20</td>
<td>(29)</td>
</tr>
<tr>
<td>Neuroleptics</td>
<td>0</td>
<td>(0)</td>
<td>4</td>
<td>(6 )</td>
</tr>
<tr>
<td>Anxiolytics/Benzo’s</td>
<td>0</td>
<td>(0)</td>
<td>15</td>
<td>(22)</td>
</tr>
<tr>
<td>LSD</td>
<td>18</td>
<td>(26)</td>
<td>9</td>
<td>(13)</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>25</td>
<td>(37)</td>
<td>14</td>
<td>(21)</td>
</tr>
<tr>
<td>Magic Mushrooms</td>
<td>2</td>
<td>(3 )</td>
<td>0</td>
<td>(0)</td>
</tr>
<tr>
<td>Solvents</td>
<td>0</td>
<td>(0)</td>
<td>1</td>
<td>(1 )</td>
</tr>
<tr>
<td>Cocaine</td>
<td>7</td>
<td>(10)</td>
<td>17</td>
<td>(25)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>68</td>
<td>(100)</td>
<td>68</td>
<td>(100)</td>
</tr>
</tbody>
</table>

The treatment group were more likely to have used opiate drugs and cocaine in the previous three months. None of the recreational group
reported opiate drug use but this group were more likely to have used alcohol, cannabis, amphetamines, LSD, and ecstasy, these results support
the classification of drug types outlined in part one of this research whereby some were considered protective of successful recreational use while others where considered antagonistic. These results fit identically with these categories and discriminate between the two groups.

The ages of first illegal drug use by the two groups are given in table 4.

TABLE 4  MEASURES OF CENTRAL TENDENCY AND DISPERSION FOR AGE BY GROUP

<table>
<thead>
<tr>
<th>GROUP</th>
<th>ARITHMETIC MEAN</th>
<th>STANDARD DEVIATION</th>
<th>RANGE (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recreational</td>
<td>16.47</td>
<td>2.70</td>
<td>13 - 25</td>
</tr>
<tr>
<td>Treatment</td>
<td>14.9</td>
<td>2.32</td>
<td>8 - 24</td>
</tr>
</tbody>
</table>

The results show a lower mean age for initial experimentation in the treatment group as well as a wider range of results with the youngest novice drug user aged 8 years.

Cannabis was the first illegal drug used by the large majority in both groups (question 3.3). 85% of the treatment group compared with 90% of the recreational group reported cannabis as the first illegal drug experience. Other drugs were uncommonly used in initiation and these are set out in table 5 below.
TABLE 5  WHICH WAS THE FIRST ILLEGAL DRUG USED
BOTH GROUPS

<table>
<thead>
<tr>
<th>TYPE OF DRUG</th>
<th>RECREATIONAL SAMPLE</th>
<th>TREATMENT SAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NUMBER</td>
<td>%</td>
</tr>
<tr>
<td>Cannabis</td>
<td>61</td>
<td>90</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>LSD</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Solvents</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Heroin</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cocaine</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>68</td>
<td>100</td>
</tr>
</tbody>
</table>

Responses to questions 3.4 and 3.5 failed to show significant differences on the dependent variable indicating that control over drug and alcohol use by income and fears concerning the illegal aspects of drug use failed to discriminate between the treatment and recreational group. Notably, a substantial majority of both the recreational group (84%) and the treatment group (72%) reported that the illegal nature of drug use had no impact on their behaviour.

Questions 3.6 and 3.7, however, discriminated significantly between the two groups. The treatment group were less likely to feel that they would still be using drugs in the same way 10 years from now while the recreational group were evenly split into yes and no responses. A Chi
Significantly more people in the recreational group felt in control of their drug use (93%) compared with the treatment group (59%). A Chi squared value of 21.166 (1 degree of freedom) gave a significance level of \( p = < .0001 \). The issue of control remains, therefore, a central feature in discriminating between recreational and problematic drug use.

Question 3.9 invites respondents to mark where they feel they are on a scale of isolation/integration. At one end their drug use is entirely to be in their own world while at the other end their drug use is entirely to be part of a group. Figure 2 demonstrates this relationship in the form of a graph. The X axis (extent of isolation - integration) can be interpreted as follows:

1. Most of my drug use is to be entirely in my own world.
2. Largely in my own world.
3. Mostly in my own world.
4. Somewhat in my own world.
5. Most of my drug use is to be somewhat part of a group.
6. Mostly part of a group.
7. Largely part of a group.
8. Entirely part of a group.

The graph in figure 2 demonstrates the distribution skew for the treatment group towards the isolation end of the scale and the skew for the
Drug Use by Social Isolation-Integration

FIGURE 2
recreational group for the integration end of the scale. A Spearman’s value of -.26727 gives P<.001. We can thus conclude that there is a significant correlation between the independent variable (reasons for drug use) and the dependent variable: recreational/treatment group membership.

Question 3.11 investigated the amount of available income spent on drugs or alcohol. A simple Chi square test gives a Chi square value of 20.36 for two degrees of freedom and a p value of < 0.01. We can therefore conclude for this sample that the treatment group spend significantly more available income on drugs or alcohol than the recreational group (table 6 below).

**TABLE 6**

<table>
<thead>
<tr>
<th>INCOME SPENT ON DRUGS/ALCOHOL BY GROUP</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOME</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>Recreational Group</td>
</tr>
<tr>
<td>Treatment Group</td>
</tr>
<tr>
<td>TOTAL</td>
</tr>
</tbody>
</table>

Concluding section three, respondents were asked whether their drug use had ever got them into trouble with the law, parents/family, school/college, work or friends. These data are shown in the block chart (figure 3 below). The discrepancy between the recreational and treatment group can
A Graph Depicting The Extent To Which Drug Use Is Associated With Problems By Group

FIGURE 3
immediately be seen. All five problem areas were analysed by $2 \times 2$ Chi square. All gave p values of $< 0.001$, enabling us to reject the null hypothesis and conclude that these independent variables discriminate significantly between the two groups.

**SECTION 4 DRUGS AND FRIENDS**

Analysis of responses to question 4.1 failed to show any significant difference between the recreational and treatment group. In both groups, the highest frequency response was that most of their friends were drug users (48% of the total sample). 32% said that some of their friends were drug users, 18% that all their friends were drug users and only 2% reported that none of their friends were drug users.

The treatment group (question 4.2) were more likely to report that their friends worried about how many drugs they used compared with the treatment group (41% and 19% respectively).

There was no difference between the groups in their responses to the question “Do you worry about looking ridiculous when you are on drugs”? (question 4.3). Both groups demonstrated identical results with 66% of the sample reporting that they did not worry about looking ridiculous and 34% of the sample saying that they did worry about looking ridiculous.

In a similar way, the question “do you worry about how much some of your friends use” (question 4.4) failed to discriminate significantly between the
recreational and treatment group. 44% of the recreational group worried about their friends' drug use compared with 55% of the treatment group.

SECTION FIVE DRUGS AND KNOWLEDGE

Significantly more recreational drug users reported finding out about the drugs they used before using them (76%) compared with the treatment group (54%). A Chi square value of 7.315 with one degree of freedom gives a significance level of .006. In rejecting the null hypothesis we conclude that the recreational group are more cautious in their experimental drug use than the treatment group as measured within this research sample.

All respondents were asked to rank in order of importance the source of their more important knowledge about drugs. Since no significant difference emerged between the recreational and treatment groups on their ranking of knowledge sources, the results have been collapsed for both groups for the analysis of these data (see table 7 below).
TABLE 7

Sources of Drug related knowledge ranked in order of perceived importance (whole sample N = 136)

<table>
<thead>
<tr>
<th>Source</th>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Own drug experience</td>
<td>54</td>
<td>29</td>
<td>7</td>
<td>4</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Media</td>
<td>2</td>
<td>10</td>
<td>40</td>
<td>26</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Parents</td>
<td>3</td>
<td>1</td>
<td>5</td>
<td>14</td>
<td>24</td>
<td>53</td>
</tr>
<tr>
<td>School</td>
<td>3</td>
<td>5</td>
<td>6</td>
<td>15</td>
<td>49</td>
<td>22</td>
</tr>
<tr>
<td>Information Leaflets</td>
<td>4</td>
<td>6</td>
<td>30</td>
<td>33</td>
<td>14</td>
<td>13</td>
</tr>
<tr>
<td>Other’s Drug Experiences</td>
<td>32</td>
<td>49</td>
<td>7</td>
<td>3</td>
<td>3</td>
<td>6</td>
</tr>
</tbody>
</table>

* all values expressed in percentages of the total sample of 136

The results indicate that “own drug experience” and “others drug experience” are most likely to be highly ranked as sources of important knowledge. Media, parents, school and information leaflets all receive consistently lower ranking by all the subjects in the study.

Question 5.3 explores the self imposed boundaries on drug types and asks “what drugs would you never use”? Table 8 lists all the drugs listed as responses to this question broken down into the recreational and treatment groups.
TABLE 8 WHAT DRUGS WOULD YOU NEVER USE?

<table>
<thead>
<tr>
<th>TYPE OF DRUG</th>
<th>RECREATIONAL</th>
<th>TREATMENT</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Methadone</td>
<td>4</td>
<td>(6)</td>
<td>3</td>
</tr>
<tr>
<td>DF118</td>
<td>4</td>
<td>(6)</td>
<td>3</td>
</tr>
<tr>
<td>Diconal</td>
<td>4</td>
<td>(6)</td>
<td>3</td>
</tr>
<tr>
<td>Heroin</td>
<td>47</td>
<td>(69)</td>
<td>25</td>
</tr>
<tr>
<td>Morphine</td>
<td>4</td>
<td>(6)</td>
<td>3</td>
</tr>
<tr>
<td>Opium</td>
<td>4</td>
<td>(6)</td>
<td>3</td>
</tr>
<tr>
<td>Palfium</td>
<td>4</td>
<td>(6)</td>
<td>3</td>
</tr>
<tr>
<td>Hypnotics/Benzo’s</td>
<td>5</td>
<td>(7)</td>
<td>7</td>
</tr>
<tr>
<td>Alcohol</td>
<td>1</td>
<td>(1)</td>
<td>4</td>
</tr>
<tr>
<td>Cannabis</td>
<td>0</td>
<td>(0)</td>
<td>2</td>
</tr>
<tr>
<td>Barbiturates</td>
<td>3</td>
<td>(4)</td>
<td>5</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>5</td>
<td>(7)</td>
<td>11</td>
</tr>
<tr>
<td>Antidepressants</td>
<td>4</td>
<td>(6)</td>
<td>3</td>
</tr>
<tr>
<td>Neuroleptics</td>
<td>5</td>
<td>(7)</td>
<td>4</td>
</tr>
<tr>
<td>Anxiolytics/Benzo’s</td>
<td>4</td>
<td>(6)</td>
<td>7</td>
</tr>
<tr>
<td>LSD</td>
<td>12</td>
<td>(18)</td>
<td>17</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>10</td>
<td>(15)</td>
<td>0</td>
</tr>
<tr>
<td>Magic Mushrooms</td>
<td>4</td>
<td>(6)</td>
<td>3</td>
</tr>
<tr>
<td>Solvents</td>
<td>10</td>
<td>(15)</td>
<td>13</td>
</tr>
<tr>
<td>Ketamine</td>
<td>16</td>
<td>(24)</td>
<td>8</td>
</tr>
<tr>
<td>Cocaine</td>
<td>11</td>
<td>(16)</td>
<td>9</td>
</tr>
<tr>
<td>Crack</td>
<td>36</td>
<td>(53)</td>
<td>19</td>
</tr>
<tr>
<td>TOTAL</td>
<td>68</td>
<td></td>
<td>68</td>
</tr>
</tbody>
</table>

Most drug types are mentioned too infrequently to conduct any meaningful analysis. However, Heroin and Crack Cocaine appeared on a large number of returned questionnaires and in both cases, were more likely to be offered by the recreational sample as a drug which they would avoid using than the treatment sample. Ketamine was also mentioned as a drug to avoid by twice as many from the recreational sample as the treatment sample while
more people in the treatment sample said they would avoid LSD and Amphetamine. Overall, however, the results of this question, with the exception of Heroin and Crack, are equivocal and point to the need to use a prompt list rather than rely on drug types which happen to come to mind. This issue is re-visited in the discussion section.

SECTION SIX DRUGS AND TROUBLE

Question 6.1, 6.2 and 6.3 looked at the extent to which drug use was controlled by fear of physical problems, fear of mental problems and lessons learnt by the mistakes of self or others respectively. Respondents were invited to indicate the extent to which these factors had influenced their drug use on an eight point Likert scale. Unfortunately, none of these factors discriminated significantly between the two groups nor were any obvious trends observed by combining the two groups and inspecting the data for the entire sample. There was a general trend, previously mentioned by the radio journalists who administered the questionnaires to the recreational drug using sample, to favour scores at the extremities of the scales rather than displaying a central tendency the reason for which remains unclear.

Question 6.4 ("Is there anything that I have neglected to ask you or that you feel is important") provided no useful information about recreational or problematic drug use but offered some useful pointers on questionnaire design and data collection. Analysis of the completed questionnaires reveals only 8 written comments out of a total sample size of 136. These
comments are not about recreational or problematic drug use but about the experience of completing the questionnaire itself. Two subjects criticise the term “drug user” and suggested “drug taker” as a more appropriate alternative. The other comments related to the tiresome experience of filling in a rather dry and unfriendly questionnaire. Four written comments observe that the person who designed the questionnaire obviously wasn’t a drug taker! These remarks are useful and will certainly inform further research development. The paucity of responses to question 6.4 may be due to the abrupt change of emphasis of ticking boxes and forced-choice Yes/No responses to an open invitation to comment in a freer way.

4.1 DISCUSSION

This discussion starts with a brief recapitulation of what has been undertaken and what has been achieved.

Following in-depth, non directive interviews with a small number of recreational drug users (n = 26), a qualitative analysis was carried out using established ethnographic principles. This revealed a framework within which successful recreational drug use appeared to thrive. This framework consisted of unwritten rules, positive peer group influences, self monitoring, and the choice of “protective” drug types, methods of administration, and environments. Although undertaken in a different cultural context, a decade apart and focussing on a broader variety of drugs, the results reported in this project reflect a similar framework to that described by Zinberg (1984) and Grund (1993).
Aspects of this framework which were judged to be most influential in the initiation and maintenance of recreational drug use were translated into a questionnaire. This descriptive study investigated whether this questionnaire produced distinct response patterns which differentiated the recreational drug using group from the problematic drug using group. The questionnaire was administered to random samples of each type of drug user, each containing 68 individuals, giving a total study population of 136. The results were analysed using non-parametric tests suitable for nominal and ordinal level data. The combined data sets therefore include both a significant qualitative and quantitative component.

**What Has Been Learned?**

Drug users approaching treatment services for help and those who do not and have not approached services for help with drug-related problems appear to differ significantly in a number of respects. Many of these significant differences confirm predictions arising from the small group, in-depth study reported in Part 1. Of equal interest are those areas in which one might expect a difference to exist but which these data fail to support. Experience, intuition and logic would suggest a common profile for recreational drug users in which they were busy, socially integrated selective about types, extent and methods of drug use, somewhat cautious of legal, mental health, physical health, social and occupational risks, having fun, and in control. The stereotypical profile of the problematic drug user in contact with treatment services would suggest that for this group, the
opposite profile would prevail. These predictions are partially borne out and partially challenged by this research project.

A reasonable attempt has been made to match the two samples for size, age and gender balance. The match is less than perfect, reflecting some of the challenges of ex-post facto research. This is a non-experimental investigation in which potentially confounding variables are more likely to occur since experimental manipulation and control of variables is limited. It should be borne in mind that the research tool used in Part II, although drawn from the findings of Part I, has not been validated and therefore interpretation of the results should acknowledge this limitation.

The data establish that the recreational sample are more likely to be employed or have student status, show a higher level of social integration (as defined above) and more likely to feel in control of their lives. Levels of significance suggest that these results are not entirely as a result of sampling error or coincidence within a population in which the independent variables and dependent variable are unrelated.

The data tend to support the hypothesis that some drugs are antagonistic to recreational use while others are protective of it. All the opiate drugs, Cocaine and Benzodiazepines were far more likely to have been used by the treatment sample while the established “party” drugs including Alcohol, Cannabis, Amphetamine, LSD, Ecstasy and Magic Mushrooms were more likely to have been used by the recreational sample.
The age of first drug use for the two groups does not differ significantly in this study. Similarly, the choice of first illegal drug used (Cannabis) does not discriminate between the two groups. The implication is that age of onset is more predictive of future drug related problems than type of drug. Notably, however, both the subject who first used Cocaine and the subject who first used Heroin come from the treatment sample.

The results suggested that drug use was more likely to be controlled by income in the recreational sample although this did not reach a level of statistical significance. Worries about the illegal aspect of drug use did not discriminate between the two samples. Over three quarters of the combined samples reported that their drug use was not reduced by worries about law breaking. This would seem to have obvious implications for criminal justice and the failure of deterrent based policies in reducing levels of consumption.

The treatment group were significantly more likely to entertain the hope that their use of drugs would have changed in ten years time. This supports the theory that recreational drug users are having fun and can see no immediate reason or need for change in comparison with the treatment group.

The independent variable which most significantly discriminated between the two groups was the concept of control. The treatment sample were six
times more likely to feel that their drug use was out of control compared with the recreational sample. The concept of control has already been examined in detail in Part 1 of this research project. It emerges as the single most powerful discriminating factor between recreational and problematic drug use and arguably could underly many of the other discriminating variables such as number of drug related problems and level of social integration.

The detailed survey conducted with recreational drug users suggested that their drug use was more gregarious and conducted in a social context. The data from the questionnaire support this and suggest that problematic drug use tends more towards isolation and the attempt to “be in my own world”. This suggests a fundamental difference between the motivation underlying recreational and problematic drug use. The former seeks to make a good time better while the latter seeks to make a bad time bearable. Drug use therefore may have a sense of priority and urgency for the treatment group which is not apparent in the recreational group. This is supported by the significant difference in allocation of financial resources. The treatment group are more likely to spend most or all of their income on drugs and alcohol in comparison with the recreational group who are most likely to spend only some of their income.

The treatment group comply reassuringly with their stereotypical profile by demonstrating significantly higher levels of drug related problems. This result should be interpreted cautiously since cause and effect can easily be
confused (see above). However, the problems reported are more likely to be the effect of drug use rather than the cause of drug use because of the careful wording of the question; “Has your drug use ever got you into trouble with ......” which attempts to clarify the causal connection.

The questionnaire failed to reveal significant differences between the groups in the area of drug use and friendship, which may reflect a limitation in questionnaire design or content. Both groups were equally likely to report that some or most of their friends were drug users, both groups tended not to worry about looking ridiculous when taking drugs and both groups were evenly split with similar numbers worrying about how many drugs their friends used and not worrying about how many drugs their friends used. Friends of the treatment group, however were significantly more likely to worry about the respondents drug use. This fits in with the idea that the treatment group used drugs in a more problematic and chaotic way but challenges the idea that they exist in isolation in a community where no-one cares or shows concern for them.

The more cautious and informed nature of recreational drug use is supported by the significant finding that the recreational group are more likely to find out about drugs before using them. However, sources of this “Really Useful Knowledge” fail to discriminate between the treatment and recreational samples. The combined data however offer suggestions about where all drugs users, whether recreational or problematic, derive their knowledge from. These data support the conclusions from Part 1 of this
research project and suggest that drug users learn about drugs from their own experience or that of significant others. The entire research sample attached little importance to media or information leaflets and less still to information from parents or the educational system.

The question intended to extend our knowledge of taboo drugs is restricted in its sensitivity by not having a check list to prompt memory. In effect therefore, only the most robust taboos will emerge in the absence of any prompting. The most frequently mentioned drug types are Heroin and Crack. Both these drugs are twice as likely to have been mentioned by the recreational sample compared with the treatment sample. Once again, Heroin (the most powerful of the opiate drugs) and Crack Cocaine feature as antagonistic to recreational drug use. Selection of either or both may influence membership of either the experimental or the treatment group since a powerful correlation is consistently demonstrated in these data.

The last section of the questionnaire did not reach statistical significance. It may be that the questionnaire was too long or that the Likert Scales were confusing. Another explanation may be that there is a genuine lack of homogeneity within the sample concerning the influence of avoiding physical or mental problems on drug use, or the extent to which the individual has learnt by trial and error. The absence of significant discrimination or correlation suggests that these are free floating variables which have little or no loading on the dependent variable in this study.
4.2 LIMITATIONS OF THIS RESEARCH PROJECT

Interpretation of the research findings must take account of a number of factors which influence the research method and data collection in this project.

Some subjects had difficulties with the Likert scale items, (Likert, 1932) and the researchers reported a tendency towards extreme values and away from central values. Some subjects commented that the extremes were not always seen as opposites. Many found the response options too rigid and wanted to make the predictable "It depends" response. A negative feature of quantitative data collection is that it seldom allows for the complexity of potential responses.

The researchers final comments on the questionnaire at the end of the data collection process are interesting and give valuable insight (unfortunately retrospective) into changes to subsequent questionnaire design and data collection. They found that the detailed non-directive method of conducting in-depth interviews worked better at engaging the enthusiasm of respondents; the questionnaire (Part II) was too long to use conveniently on the street or in public premises, but not detailed enough and too rigid in employing "forced choice" answers to involve the respondent in any deeper or more meaningful analysis of the issue of drug use, recreational or otherwise. As the two researchers put it: "Collecting
the data for Part I was fun, collecting the data for Part II was a chore”.
Instead of encouraging discussion, they were continually trying to confine
voluble subjects to Yes/No responses.

A further difficulty is that of sampling. Extrapolation from a limited cohort
can only be undertaken with confidence if the sampling technique is truly
random, and thus representative of a wider population.

The recreational sample was opportunistic. Respondents were selected by
virtue of their acquaintance with the researchers. The clinical sample were
more likely to be male and more likely to be primary opiate users since
these are the defining characteristics of individuals approaching drug teams
for help throughout the United Kingdom. An additional problem is that all
the data on both recreational and treatment groups were generated in the
towns of Brighton and Worthing in Sussex. This represents a geographical
bias and may create a “locality” effect in interpreting the results.

Sampling bias is reduced however, by the sample size which ensures a
broader spectrum within each of the research samples. Only new referrals
to the drug agencies were included in the treatment group to remove the
problem of experimental selection (choosing the most helpful and co-
operative members of your caseload to answer yet another research
questionnaire). Truly random sampling of an illegal activity remains,
therefore, an utopian ideal which presents significant difficulties in practice.
Improvements could be made to the questionnaire in the light of experience. The concept of fun is not included and might be useful in discriminating between recreational and problematic drug use. The strong taboo against intravenous drug use is not explored in the questionnaire although it was clearly identified in Part 1 of the research. The questions which ask respondents to list drugs recently used or consciously avoided should be supported by a checklist to jog the memory and ensure uniformity of response. In the absence of checklists, responses to these questions should be regarded as incomplete data sets.

The questions employing Likert scales require further clarification. Because instructions to subjects completing the questionnaire had not been standardised, no instructions were given so as to eliminate researcher variability. In effect, individuals had to interpret these items in whatever way they chose leading to a variability in response which may explain the lack of discrimination or correlation in the response sets.

Another weakness in the research design which should not be overlooked is the difficulty in operationalising the underlying constructs of recreational drug use and problematic drug use. In effect, this distinction has been oversimplified by defining recreational drug users as those people who use drugs but have not approached drug treatment services and defining individuals who use drugs problematically as anyone who approaches a drug treatment service. While this definition has the merit of simplicity, it
lacks sophistication. It is self-evident that there are many problematic drug users “out there” who, for one reason or another, have not been able or have decided not to approach a treatment agency. This decision may be motivated by fears regarding confidentiality, the perception that the agency could not help them with their problem anyway, the fear of meeting other drug users or a simple disaffection with authority. On the other hand, not everyone who approaches a drug treatment agency has a drug problem. Some recreational users come into contact with agencies because they have been arrested for possession of small amounts of Cannabis or Amphetamine and whose chief problem is not that they use drugs, but that they have been apprehended.

Given, therefore, that the operational definition which discriminates the two groups is weak, significant differences demonstrated between the two groups are more robust. It is also reasonable to conclude that this potential contamination effect between the two groups has not confounded the research effort although it may have weakened the significance of the results.

4.3 FUTURE DIRECTIONS

The research findings arising from the Really Useful Knowledge project have potentially useful applications with both treatment and recreational drug using populations. The public health messages couched in terms of blanket prohibition can be considerably refined. The distinction between
“protective” and “antagonistic” and drug taking could provide a useful training programme which would offer a panoramic perspective, ranking drug types and drug behaviours in order of dangerousness. These messages, especially if delivered through the peer training medium would carry additional weight since they would resonate with the attitudes, beliefs and experiences already held by young people about drug use generally.

The dialogue on safer drug use currently revolves around a particular high risk behaviour: that of sharing injecting equipment. The debate on safer drug use could be usefully extended by including antagonistic drugs and drug behaviours in the unsafe category whilst including protective drugs and protective drug behaviours in the safer category. The problem with utilising any of this research has already been mentioned in the discussion of the work of Norman Zinberg (see above) and arises from the illegal nature of all drug taking. In this context it is difficult to make public distinctions between one type of drug and another since this implicitly condones some illegal activity. Nevertheless, even the Misuse of Drugs Act (1979) acknowledges that all drugs are not the same. Class A drugs carry heavier penalties than Class B and Class C respectively. Recent legislation (BBC September 1995) acknowledges the specific dangers surrounding the use of Temazepam, a hypnotic Benzodiazepine, which now carries a two year prison sentence for unlawful possession.

In conclusion, there is a body of Really Useful Knowledge which informs and governs the recreational drug use of many young people. Its current
acquisition is informal and unreliable and could probably be utilised in a public health campaign which identified and promoted protective aspects of drug use whilst warning against antagonistic aspects. A similar checklist could be employed with individuals in treatment to help those who are neither ready or able to abandon drug use altogether to re-introduce factors which are protective of control and abandon those which are antagonistic to control.


APPENDIX FIRST DRAFT

REALLY USEFUL KNOWLEDGE QUESTIONNAIRE

DRUG USE AND LIFESTYLES

Section 1 A Few Personal Details

1.1 What is your age? __________

1.2 What is your gender? M/F

1.3 Are you currently: a) employed

b) unemployed

c) a student

d) employed in the home

Section 2 Lifestyle Choices

2.1 Do you like exercise? Y/N

2.2 Do you like dancing? Y/N

2.3 Do you like team sports? Y/N

2.4 Do you enjoy the company of others? Y/N

2.5 In general, do you feel in control of your life? Y/N

Section 3 Drug Choices (including Alcohol)

3.1 Which drugs have you used in the last four weeks including alcohol

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________
3.2  At what age did you first use an illegal drug? ____________ yrs

3.3  Which was the first illegal drug that you used? ______________

3.4  Is your drug and alcohol use controlled by your legitimate income? Y/N

3.5  Do worries about breaking the law reduce your use of drugs? Y/N

3.6  Do you think you will still be using drugs in the same way 10 years from now? Y/N

3.7  In general, do you feel in control of your drug use? Y/N

3.8  Have you ever approached a drug agency for help in regaining control over your drug use? Y/N

3.9  Mark where you feel you are on the following scales:
I use drugs to:
protect myself 0 1 2 3 4 5 6 7 get closer
from people 1 2 3 4 5 6 7 get closer
to people

3.10 I rate alcohol as:

a social drug 0 1 2 3 4 5 6 7 an anti-social drug

3.11 How much of your available income do you spend on drugs or alcohol?
some
most
all

3.12 Has your drug use ever got you into trouble with (tick all that apply)
the law
parents/family
school/college
work
friends

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Section 4  Drugs and Friends

4.1  How many of your friends are drug users?  
- none  
- some  
- most  
- all

4.2  Do your friends worry about how much you use?  Y/N

4.3  Are you worried about looking ridiculous when you’ve taken a lot?  Y/N

4.4  Do you worry about how much some of your friends use?  Y/N

Section 5  Drugs and Knowledge

5.1  Did you find out about the drugs you have used before using them?  Y/N

5.2  Where does your most important knowledge about drugs come from?  (Rank in order of importance)

6 = most important
1 = lease important

- own drug experience
- TV newspapers, radio etc
- parents
- school
- drug information leaflets
- friends or others’ drug experience

5.3  What drugs would you never use?


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Section 6  Drugs and Trouble

6.1  To what extent is your drug use controlled by the fear of mental problems?

not at all 0 1 2 3 4 5 6 7 entirely

6.2  Is your drug use controlled by the fear of physical problems?

not at all 0 1 2 3 4 5 6 7 entirely

6.3  To what extent do you think you have learned by the mistakes you or your friends have made?

not at all 0 1 2 3 4 5 6 7 a great deal

6.4  Is there anything that I’ve neglected to ask you or that you feel is important?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Thank you for taking part in this research.
DRUG USE AND LIFE STYLES

Section 1  A Few Personal Details

1.1 What is your age?
1.2 What is your gender?
1.3 Are you currently:  
   a) employed................................. ( )
   b) unemployed........................... ( )
   c) a student............................. ( )
   d) employed in the home............. ( )

Section 2  Lifestyle Choices

2.1 Do you exercise ?  Y/N
2.2 Do you go dancing ?  Y/N
2.3 Do you take part in team sports ?  Y/N
2.4 Do you enjoy the company of others ?  Y/N
2.5 In general, do you feel in control of your life ?  Y/N

Section 3  Drug Choices (including alcohol)

3.1 Which drugs have you used in the last 3 months including alcohol

________________________

________________________

________________________

________________________
3.2 At what age did you first use an illegal drug other than alcohol? _____ yrs

3.3 Which was the first illegal drug that you used? ________

3.4 Is your drug and alcohol use controlled by your income? Y/N

3.5 Do worries about breaking the law reduce your use of drugs? Y/N

3.6 Do you think you will still be using drugs in the same way 10 years from now? Y/N

3.7 In general do you feel in control of your drug use at present? Y/N

3.8 Have you ever approached a drug agency for help in regaining control over your drug use? Y/N

3.9 Mark where you feel you are on the following scales:

Most of my drug use is to:

be in my own world 0 1 2 3 4 5 6 7 be part of a group.

3.10 I feel alcohol is:

a social drug 0 1 2 3 4 5 6 7 an anti-social drug

3.11 How much of your available income do you spend on drugs or alcohol?

some ( )
most ( )
all ( )
3.12 Has your drug use ever got you in trouble with
(tick all that apply)

- the law ( )
- parents/family ( )
- school/college ( )
- work ( )
- friends ( )

Section 4  Drugs and Friends

4.1 How many of your friends are drug users?

- none ( )
- some ( )
- most ( )
- all ( )

4.2 Do your friends worry about how much you use?  Y/N

4.3 Do you worry about looking ridiculous when you're on drugs?  Y/N

4.4 Do you worry about how much some of your friends use?  Y/N

Section 5  Drugs and Knowledge

5.1 Did you find out about the drugs you have used before using them?  Y/N

5.2 Where does your most important knowledge about drugs come from? (Rank in order of importance)

- own drug experience ( )
- TV newspapers, radio, etc ( )
- parents ( )
- school ( )
- drug information leaflets ( )
- friends or others' drug experience ( )

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5.3 What drugs would you never use?


Section 6 Drugs and Trouble

6.1 Is your drug use controlled by the fear of physical problems?
not at all 0 1 2 3 4 5 6 7 entirely

6.2 Is your drug use controlled by the fear of mental problems?
not at all 0 1 2 3 4 5 6 7 entirely

6.3 To what extent do you think you have learned by the mistakes you or your friends have made?
not at all 0 1 2 3 4 5 6 7 a great deal

6.4 Is there anything that I've neglected to ask you or that you feel is important?


Thank you for taking part in this research.
POST QUALIFICATION COURSES AND TRAINING UNDERTAKEN

Portage Project - Goal setting and training carers, Crawley, August 1982

One day conference on research methods in clinical psychology - St. George’s Hospital, June 1983

Family Psychotherapy Techniques, Crawley, November and December 1983 (Dr. Jim Birch)

Communication with Psychiatric Patients Netherne Post Graduate Medical Centre, May 1984

Supervisor Training, Surrey University Guildford, July 1985

The Grammar of Psychotherapy (Dr. Stuart Lieberman) series of seminars Autumn 1985

Substance Misuse “Recognition, assessment and intervention” University of Kent, Alcohol Interventions Training Unit, September 1986

Audio visual techniques in treatment and supervision, Regional Training Centre, October 1987

Sexuality and Safer Sex Institute of Psychiatry, Maudsley Hospital, London, December 1988

One week study trip to Amsterdam, November 1988

The Growth of Psychologists in Private Practice, Haywards Heath, Mid Downs Health Authority, July 1988

Foundation Management Course (two weeks) Worthing District Health Authority, April 1989

Summer School in the Addictions, Addiction Research Centre, Maudsley Hospital, London, September 1989

East Sussex Drug Advisory Committee “Training the Trainers”, Hastings, March 1990

First International Conference on the Reduction of Drug Related Harm, Liverpool, April 1990

Regional Drug Workers Training Day, St. Georges Hospital, October 1990

Two week study trip to drug services in New York, November 1990
Second International Conference on the Reduction of Drug Related Harm, Barcelona, March 1991

Improving Service Provision and Practical Skills Sharing in Substance Misuse, Queen Mary's University Hospital, Roehampton Post Graduate Medical Centre, July 1991

Equal Opportunities in the NHS, Southlands Hospital Training Unit, Shoreham, March 1992

Fourth International Conference on the Reduction of Drug Related Harm, Rotterdam Netherlands, March 1993

The Implementation of the Community Care Act, Royal College of Physicians, London, April 1993

Mental Health Services “A conference for Stakeholders”, Shoreham, April 1993

Brief Solution Focus Therapy, London, July 1993

Treating Adult Survivors of Childhood Sex Abuse, Worthing, August 1993

The Fifth International Conference on the Reduction of Drug Related Harm, Toronto Canada, March 1994

Developing Supervision Skills, University of Surrey, May 1994

Post Traumatic Stress Disorder in Children, University of Surrey, December 1994

Sixth International Conference on Drug Related Harm, Florence, March 1995

Neuropsychological Measurement in Health Psychology, Surrey University, September 1995
M. PSYCHOL. COURSE (Clinical Specialisation)

University of Liverpool, in conjunction with the Mersey Regional Health Authority.

A Post Graduate Training Course in Clinical Psychology 1979-1981

The Liverpool Masters Degree in Clinical Psychology was established in 1961 by Dr. Ralph Hetherington in conjunction with the Liverpool University Departments of Psychology and Psychiatry. The aim of the course was to equip the post graduate trainee with a theoretical understanding of a wide range of clinical problems and approaches, together with basic clinical skills and a variety of practical placement experiences as would be required by a basic grade clinical psychologist.

The course was of two full calendar years in duration. The academic input was largely confined to three ten week academic terms at the University so that all the remaining time, excluding holidays and revision leave, was spent on full-time clinical placements.

Year One

The major goals in the first year were:

A To provide a general orientation to the field of clinical psychology, the methods and approaches and fundamental practical ethical issues.
B. To teach a number of basic practical skills relevant to the acquisition of clinical experience including interviewing skills, psychometric and observational methods.

C. To introduce trainees to the general problem solving model and examples of clinical formulation.

D. To foster general communication skills by means of seminars and role-play exercise.

E. To introduce the fields of mental health and mental disorder.

F. To develop training skills by means of peer led seminars and topic based lectures to first and second year medical students.

G. To undertake core placements in adult mental health, people with learning disabilities, and the psychology of children’s problems.

Year Two

During the second year the course was divided as follows:

One full academic day per week.

One full project day per week
Three full days on clinical placement per week

The focus of the academic input was the application of the skills and data base required during the first year to the solution of clinical problems.

Other aspects of the second year included dissertation/project seminars, journal seminars and a range of visiting speakers and workshops. The time component for dissertation preparation amounted to a total of 40 days, including selection of topic, design, data collection, data analysis and write-up.

During the second year specialist placements could be selected by trainees.

My chosen placements were:

Three month placement at Moss Side Special Hospital.

Three month placement in Neuropsychology.

Three month placement in an alcohol detox and treatment clinic.

These placements reflected my special interests at that time. My Masters Degree Thesis investigated the effects of aneurysms of the middle cerebral artery. My final placement at the alcohol treatment clinic attached to Rainhill Hospital in Merseyside generated the abiding interest in addictive behaviour which has characterised my professional development since qualifying.
Evaluation

At the end of the first year trainees sat written papers in the following subjects:

1. Assessment and measurement
2. Behavioural changes and treatment
3. Abnormal behaviour of children and adults
4. Allied disciplines including neurology, neuropsychology, psychiatry and general medicine.

At the end of the second year trainees were examined by Viva Voce examination by the internal and external examiners on their dissertation and two special case reports. These were marked on a pass/fail basis.

In addition to the written examinations, dissertation and case reports, a continuous monitoring system for assessment of clinical experience and competence was operated supervisors placement evaluation and the overall judgement of the academic lecturing staff were included in the final decision to award the Degree of Master of Psychology in Clinical Specialisation.

A list of general courses (Appendix A) and specialised courses (Appendix B) completes this brief summary of the Liverpool Clinical Psychology course 1979 to 1981.
APPENDIX A

GENERAL COURSES

TOPIC

1. FORMULATION OF CLINICAL PROBLEMS
2. INTERVIEWING
3. PSYCHOMETRICS
4. ISSUES AND APPROACHES IN CLINICAL PSYCHOLOGY
5. INTRODUCTION TO THERAPEUTIC TECHNIQUES AND BEHAVIOUR THERAPY
6. PSYCHOTHERAPY
7. APPLIED BEHAVIOUR ANALYSIS (A.B.A.)/BEHAVIOUR MODIFICATION
8. EXPERIMENTAL PSYCHOPATHOLOGY
APPENDIX B

SPECIALISED COURSES

TOPIC

1. CHILD CLINICAL PSYCHOLOGY
2. CHILD DEVELOPMENT
3. THE CLINICAL PSYCHOLOGY OF AGEING
4. MENTAL HANDICAP
5. PSYCHIATRY
6. PSYCHOLOGY IN RELATION TO GENERAL MEDICINE
7. CLINICAL NEUROPSYCHOLOGY
8. PSYCHOPHARMACOLOGY
9. PSYCHOPHYSIOLOGY
10. NEUROANATOMY
11. NEUROLOGY
12. INTRODUCTION TO COMPUTING
PUBLICATIONS


George, M., and Fraser, A. “When the Cats Away...”. Drugs Arena, Journal of the National Drugs Intelligence Unit issue number 8 August, 1989


George, M., and Fraser, A. (1990) “The Role of the Police in Harm Reduction through their operations against a heroin using community” proceedings of the first International Conference on Drug Related Harm, Liverpool April 9th-12th

George, M., and Fraser, A. (1990) “Seadown” Part III - “How goes the war on drugs - talking to the troops”. Drugs Arena, Issue 10 National Drugs Intelligence Unit pp.44-47


