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9-1-2004

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Recommended Citation
Buchanan, J. (2004) 'Tackling Problem Drug Use A New Conceptual Framework'.Social Work in Mental Health, 2(2&3), 117-138

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Tackling Problem Drug Use: A New Conceptual Framework

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Abstract
Successful 'recovery' from long term problem drug use has depended largely upon understanding and tackling the physiological and psychological nature of drug dependence, however, drawing upon research and practice in Liverpool, England, the author questions whether this discourse is sufficient given the changing nature, context and attitudes towards drug consumption in the twenty first century. This article emphasises the importance of incorporating structural and social factors. Drawing upon qualitative data from three separate studies the author illustrates how stigmatisation, marginalisation and social exclusion are significant debilitating components that have tended to be overlooked. This paper contributes new insights into the damaging impact of political rhetoric and structural discrimination that has placed many long-term drug users vulnerable to relapse. In response to these findings the author offers a new conceptual framework for practice that incorporates and promotes an understanding of the social nature and context of long term drug dependence.

Key Words
Drugs, social exclusion, substance misuse, drug abuse, addiction, discrimination, social work

Introduction
Based on twenty years research and practice with dependent drug users in Liverpool, England the author argues that a new paradigm is required to inform social welfare intervention with long-term dependent drug users. Existing theoretical perspectives promoted in the 1960s and 1970s such as the 12 step programme, cycle of change, Methadone Maintenance Therapy, inpatient detoxification and therapeutic communities all have considerable merit. They continue to be used with varying degrees of success, but they remain heavily based upon physiological and psychological perspectives with the emphasis upon motivation, commitment and tackling physical dependency**.** This paper draws upon three separate qualitative research studies in Liverpool, that involved semi structured interviews with 200 known problem drug users. The studies recognised the importance of user led research and for policy makers to listen to the messages from the users' themselves. These studies sought to ascertain; the views, suggestions and experiences of drug users in respect of what was helping or hindering them from giving up a drug dominated lifestyle. The findings suggest that the significant social and cultural changes in the late 20th century have diluted the impact and effectiveness of traditional approaches to assist long term dependent drug users. Drawing upon the messages from the drugs users themselves, this paper will highlight the debilitating nature of marginalisation and social exclusion that many long term problem drug users have experienced. It concludes by suggesting a new social model to understand and conceptualise the process of recovery from drug dependence, one that incorporates social reintegration, anti-discrimination and traditional social work values.

Changing Nature & Context
In the 1960s and 1970s, drug use in the UK was largely isolated and confined to a relatively small section of society which tended to use drugs as a symbol of protest and rebellion (Royal College of

Psychiatrists 2001). At the same time many saw illicit drug use as a potentially dangerous and deviant activity, which was to be avoided. However, the past 30 years has seen rapid social change, nationally and globally. In many countries taking illegal drugs is now regarded as one of many adolescent experiences. In the UK 49 per cent of young people aged 16 to 29 admit to taking a prohibited drug (Ramsay & Partridge 1999 p.viii). A longitudinal study involving a sample of over 500 teenagers from schools in North West England identified that, by the time they had reached the age of 18yrs old, over 64% had tried an illegal drug (Parker et al 1998 p.85). Illegal drugs are now easily accessible in virtually any part of the UK through carefully developed networks, greatly assisted by the widespread use and availability of mobile phones (May et al 2000). Knowledge and understanding of the true nature and risk of illegal drugs is improving, particularly in relation to cannabis. There is more of a willingness to speak openly, for example the Independent Inquiry by the UK Police Foundation stated:

> *But by any of the main criteria of harm- mortality, morbidity, toxicity, addictiveness, and relationships with crime – it [cannabis] is less harmful to the individual and society than any other of the major illicit drugs, or than alcohol and tobacco '* Police Foundation (2000 p.7)

While recreational use of cannabis can for some people, be relatively unproblematic, others drugs, such as heroin and crack cocaine, are more likely to lead to difficulties and dependence. What is interesting is that many young people are making well informed risk assessments when deciding which drugs they use with cannabis, poppers and amphetamine being the most popular (Measham et al 2001). This awareness and distinction between different illegal substances doesn't appear to be acknowledged or recognised by a UK government rhetoric that prefers a 'blanket' approach: '*All drugs are harmful and enforcement against all illegal substances will continue '* (Her Majesty's Government 1998:3), though more recently some distinctions are beginning to emerge with the proposed reclassification of cannabis.

For many decades alcohol and tobacco have been the established and heavily promoted recreational drugs of choice, but as with many other 'pillars' of social life this dominant 'cultural choice' is being challenged. Some individuals and sections of society have already made informed choices to select different recreational drugs, albeit ones that are currently categorised as illegal. Indeed, uncertainty, choice, diversity and risk taking have become key themes of post-modern life. In this context it becomes much easier to view taking illicit drugs as just another of many life choice options, all involving inherent risks and benefits. Regrettably, some of the most dangerous risks to taking illegal drugs are by-products of the illegal status of the drug, rather than the substance itself. It can be argued that many young people are choosing substances that are, if a clean legal supply could be obtained, far less damaging than the heavily promoted commercial substances; alcohol and tobacco.

While society and the nature and extent of drug taking has changed significantly over the past two decades, the approach to the problem of illicit drugs in the UK has not sufficiently adapted to take into account this changing social, political and economic environment. The UK government's 10-year drug strategy (Her Majesty's Government 1998) promotes the 'war on drugs' rhetoric and sets out to eradicate the so-called 'menace' and 'threat' of any substance that is not legal. This has led to a closer alliance between the UK and the U.S. In both countries drug policy and drug treatment is locked into the criminal justice system resulting in escalating numbers of drug users held in overcrowded prisons. Both countries are experiencing a prison crisis with numbers escalating out of control. In 1990 the U.S. incarcerated 458 people per 100,000 residents, by the year 2000 it had risen to a staggering 699 people per 100,000. The rate of incarceration increased so much in the U.S. since they declared 'war on drugs,' that apart from Russia, the U.S. now incarcerate more of their people than any other nation in the world (US Department of Justice 2001). In 1990 the prison population in England & Wales was 46,504, by the year 2000 it has increased drastically to 65,993;

125 people per 100,000 residents. While significantly less than the U.S, the UK now has the second highest incarceration rate in the European Union (Hansard 1990, Walmsley 2000). A recent survey indicated that 51 per cent of male now on remand and 54 per cent of female remand reported drug dependency problem (DoH 2001). The use of the criminal justice system and ultimately incarceration, to tackle widespread illicit drug consumption in post modern society is increasingly under scrutiny and criticism from a wider audience, *The Lancet* commented:

> *'Since the 1970s, the USA has spent billions in a largely futile effort to stem the influx of drugs, imprisoned hundreds of thousands of men and women, many with long sentences for minor offences, and poured billions into media and school-based education campaigns of questionable effectiveness'* (Lancet Editorial 2001)

As illicit drug use becomes a mainstream activity, drug policies that lean heavily upon the criminal justice system to wage war on drugs are creating a spiralling prison population and a growing concern regarding human right violations, as Karim Murji explains;

> *'the view that the state has a paternalistic duty to stop people from harming themselves by taking drugs is contradictory and incoherent, since there are other potentially harmful activities, for example, people engaging in dangerous sports, that are not treated in the same way'* (Murji 1998 p56)

Illicit drug taking has become an accepted life choice, particularly amongst the under 40s, while at the same time, those in power (usually the over 40s) attempt to persuade society that all illegal drugs are dangerous and that people should unite to eradicate them. This promotes the illusion that such a goal is not only morally 'right', but also achievable. The creation of this divisive 'moral high ground' of legal drug users (alcohol and tobacco) has serious implications and consequences for illegal drug users and drug workers who observe a growing chasm between the rhetoric concerning the risks and dangers of drugs, and the reality of their own personal experiences.

In recent years UK political parties have been competing with one another to be seen to be winning the political war on drugs by developing tougher and less tolerant policies (Buchanan & Young 1998), such as the recently introduced Drug Treatment and Testing Orders, and Abstention (*and drug testing*) Orders for offenders susceptible to taking illegal drugs. Inevitably, this not only results in harsher and less humane policies and practices, but also a hardening of attitudes towards those dependent on illegal drugs. In maintaining power and winning political popularity governments' benefit by creating enemies that they then can be seen to be protecting their people from. Societies can then unite, waging war against 'suitable enemies' (Christie 1986), and drug users have become a convenient group to demonise (Van Ree 1997). Some of the harshest government policies towards drugs and drug users in recent years have been located in the United States and some of the Nordic countries. Within these countries some academics like Trebach (1987) in the United States, and Christie & Bruun (1985) in the Nordic countries, have questioned the rationale and validity of such hostile and counter productive policies. Their criticism of harsh drug policies that promote war against illegal drugs has, sadly, not always been welcomed or appreciated

In countries that wage war on the enemy of illegal drugs, those who are ascribed the label 'druggie' or 'smackhead' find themselves not only socially marginalised and isolated, but subject to hostility and distrust. The war on drugs is a war on drug users, a civil war against an enemy within (Buchanan & Young 2000). Within this climate, attempts by recovering dependent drug users to find understanding, friendship and other opportunities to socially reintegrate with the wider population tend to quickly fail. This reality and impact of this experience needs careful understanding if agencies are to effectively assist dependent drug users on the road to recovery. The social dimension has

been largely overlooked by 'treatment' agencies which have concentrated upon tackling the physiological and psychological aspects of dependency, along with a growing emphasis (promoted by the involvement of correctional agencies), to protect society.

The Limitations of a Physiological Approach

Some physiologically dependent drug users are so intoxicated and out of control that it is difficult for them to make rational choices until they become drug free, a situation not uncommon with heavy long-term use of alcohol, heroin or benzodiazepines. However, some professionals wrongly perceive illegal drugs as inherently 'bad' to the extent that rational decision making is not possible until the person becomes drug free, and that illegal drugs are incompatible with a normal healthy life. Abstinence based workers see the removal of all illegal substances from the blood stream as the *only* viable option for recovery. Once 'addicts' are detoxed they gain the status of an 'ex-addict', and this status can be regularly and randomly monitored by increasingly more sophisticated drug testing on blood, urine, saliva, hair etc.

Abstentionists tend to regard clean legal substitute drugs as a poor alternative, because the person is still physically dependent, and concern is expressed because methadone is just as addictive as heroin itself (Robson 1999). While this is physiologically accurate, it is potentially misleading because it presents drug dependency within a medicalised conceptual framework that sees drug dependence as essentially a physical addiction. This has implications for policy and practice. For example, in Merseyside, England so convinced by the need to set her son free from physical dependence upon the 'evils' of heroin, one parent literally chained her son to the banister rail so he was restricted and only able to wander between his bedroom and the bathroom. This continued for three weeks until he became physically drug free, and therefore an ex-addict. Other strategies to become drug free have included; holidays abroad to physically withdraw, while others have sought imprisonment (though this can hardly be regarded as a drug free environment). To those who place heavy emphasis on the physiological nature of dependence it comes as something of a shock, (as many drug users have testified), to discover the cravings, the stomach cramps and sweats can all come flooding back once set free and back in the original environment where they are exposed to well established psychological and social cues and triggers. It doesn't seem to matter how long the person was away from the environment, or how long they have been drug free. When the young man who was chained to the banister rail was released by his mother, he immediately returned to his heroin habit.

While the physiological aspect of problem drug use needs to be taken seriously, it is clearly just one component of drug dependence. It does not in itself provide an adequate understanding of dependence, and can lead to the exclusive promotion of abstinence-only programmes, suggesting that harm reduction merely condones or prolongs drug taking. However, many dependent drug users are able to live normal and healthy lives while maintained on legally prescribed substitute drugs (McDermott 2001), but sadly, access to clean legal drugs is severely limited, and in many Health Authorities are unwilling to provide clean injectable drugs. The preoccupation with physical withdrawal can also lead to a failure to recognise other crucial aspects of dependence. Drucker highlights this point;

> '*In an environment frightened with powerful moral and legal reactions to the use of drugs, the stigma attached to drugs may come to be a more important factor than the biology of addiction, the demonization of drugs and the criminalization of the drug user (i.e. the war on drugs) could be more damaging to the individual and society than drug use or addiction'* (Drucker 2000 p.31)

The need for a Psychological Approach

In response to the limitations of a physiological approach, psychologist have usefully identified and introduced various cognitive behavioural theories to the field of drug dependence, including social learning theory (Bandura 1977), cognitive therapy (Beck 1979), motivational interviewing (Miller & Rollnick 1991) and the cycle of change (Prochaska et al 1992). These insights have enabled a more complete understanding of the nature of drug dependence beyond the limited understanding of physical addiction. This has provided new knowledge in understanding triggers, craving, relapse, the development of learnt (habitual) behaviour, and of particular importance, the assessment of motivation. Incorporating the psychological dimension has enabled more productive work to be carried out with a wider range of drug users, including those who are not necessarily wanting to become drug free, but seeking help to regain control over aspects of their life.

The integration of the physiological and the psychological dimensions of drug dependence largely informed the treatment of UK dependent drug users. Policy has also been influenced by a pragmatic strategy of 'harm reduction' promoted by the Government Advisory Committee in the late 1980s (Advisory Council On The Misuse Of Drugs 1988). This strategy was based on the premise that HIV posed a greater threat than drug use itself, therefore, agencies had to be prepared to accept continued drug use in order to develop relationships with the drug using community and encourage safer practices to protect the spread of infection to the non drug using population. Controversially, this involved the supply of free clean needles/syringes, free condoms and maintenance prescribing of substitute drugs. Some clinicians even prescribed amphetamine and heroin to dependent drug users, sometimes in injectable form (ampoules). Harm reduction was reluctantly embraced as agencies felt obliged by their responsibility to protect the non-drug using population from the risk of HIV/AIDS (Riley & O'Hare 2000). However, as the incidences of AIDS cases related to injecting drug use began to fall significantly in the mid 1990s across EU countries (European Monitoring Centre For Drugs And Drug Addiction 1999), interestingly, so has the prominence and practice of harm reduction. This is not surprising given that harm reduction has not been accepted by the United Nations Drug Abuse Control and Crime Prevention UNDCCP. Hartnoll identifies the problem of harm reduction for some countries such as the United States government;

> '*it lacks commitment to a drug free goal, accepts or condones continued use of drugs, and implies a hidden agenda of decriminalisation or legalisation*.' (Hartnoll 1998 p.240)

UK practice with drug users has then, been shaped by three separate frameworks of understanding: physiological dependence, psychological approaches and the pragmatic philosophy of harm reduction. The promotion of harm reduction resulted in more accessible and appropriate 'user friendly' services for drug users, but the actual practice of harm reduction tended to be limited and often confined to narrow health interpretations. While the physiological approach tended to subscribe to pathological notions of dependence promoting ideas of the 'demon' drink or drug, the psychological approaches also run the risk of decontextualising dependent drug users, suggesting dependence can largely be controlled by internal adjustments in thinking, motivation or the development of cognitive behavioural techniques. All three frameworks offer an important contribution, but they each give limited attention to the social, political and economic context of drug taking in postmodern society. Many socially excluded dependent drug users in the UK struggle to break out of a drug centred existence, even when they become physically drug free and display an abundance of psychological insight and self motivation. These drug users face a more difficult challenge of overcoming the many layers of discrimination and social exclusion, which have become a by product of government rhetoric and policy on drugs.

Getting Tough on Drug Use

In the mid 1990s the UK government abandoned the pragmatic 'British System' which was largely based upon prescribing heroin and substitute drugs through treatment in the Health Service (South 1997), which had has for so long been the backbone of UK practice, and shifted to the US model with a focus upon compulsory treatment, and abstinence through the Criminal Justice System. Interestingly, Government press releases began using dramatic language describing drugs as a scourge on communities, as the cause of most criminal offences, the cause of family breakdown, a social menace, and a threat to the fabric of society. Tony Blair UK Prime Minister called on the nation to *'break once and for all the vicious cycle of drugs and crime which wrecks lives and threatens communities'* (Her Majesty's Government 1998 p.3). As the rhetoric gathers momentum, the focus of unease, the personification of the drug problem is clearly targeted at drug users and drug pushers. A press release from the UK Treasury Department announcing £300 million to fight drugs stated;

> *''hardly a family is unaffected by the evil of drugs… Drug-related crime blights our communities. It destroys families and young lives and fuels a wide range of criminal activity, including burglary and robbery….. We won't tolerate the menace of drugs in our communities – it causes misery and costs lives…. This new money will enable agencies to step up their fight against drugs and the crime it breeds. It will get drug dealers off our kids' backs and into prison and help safeguard our communities' (HM Treasury 2001)*

What is missing is an understanding that those who trade on drugs are in the majority of cases those who have also become dependent upon drugs. Most users tend to buy for or sell to friends at some point or other, despite the fact that the offence of supplying drugs carries a lengthy prison sentence. The distinction between user and pusher is not as clear as it is portrayed.

The War on Drugs rhetoric promoted by ex Prime Minister Lady Thatcher, has served to demonise, isolate and discriminate against drug users. The institutionalised use of prejudice, power and propaganda to promote discriminatory thinking towards anyone using illegal substances is highly questionable. History tells us that other groups have endured similar experiences such as black people, gay/lesbian people, travellers and women, and many continue to do so. Not before time, many of these discriminatory perspectives have been challenged (Thompson 2001), and the damaging and offensive stereotypes have been exposed, - though further work is still needed.

Sadly, while progress is made to tackle discrimination to one group, new groups emerge, such as drug users, who are subject to *personal, cultural and structural* (Thompson 2001) discrimination. Like many other discriminated groups, some drug users have internalised the negative and harsh stereotypes imposed upon them, leaving them with poor confidence, low self esteem, low aspirations and little self worth (Buchanan & Young 1996). Social work seeks to combat discrimination in all forms but the experiences of drug users tend to go largely unnoticed and are rarely mentioned as a discriminated group.

Drug Users – A Scapegoat?

Drawing upon three separate qualitative research studies (Goldson et al 1995, Buchanan & Young 1996, Buchanan & Young 1998a) involving semi structured interviews with 200 known problem drug users in Merseyside illustrates how the war on drugs has served to legitimise and reinforce structural discrimination against drug users. The three commissioned research studies involved listening to the views of problem drug users with a common shared aim to identify the barriers that hinder their capacity to regain control of their drug habit, and to listen to the suggestions from the drug users themselves about improvements in services to enable social reintegration. The first two studies led to the establishment of Day Centre provision (Bootle, Merseyside) and a Structured Day Programme

(Liverpool, Merseyside). The third study involved action research interviewing the drug users who attended the Structured Day Programme, listening and recording their experiences. The studies all placed importance upon listening to the drug users and sought through the research to give them a voice. Common themes emerged from the drug users interviewed in these three studies;

- Their social dislocation
- Their poor experiences of education and employment
- Their lack of realistic opportunities and hope
- Their isolation from a non drug using population
- A sense of stigma and low self esteem

This article seeks to promote the voice of the drug users involved in the research. Allowing their messages concerning the impact that social exclusion and discrimination has upon them to be heard and understood. Many drug users who seek social reintegration have been unable to achieving it, this has not always been due to their own inability to become stable or drug free, but by a 'wall of exclusion', that has ghettoised problem drug users. The research illustrated how many drug users on Merseyside felt socially stranded, largely forgotten, with little hope or alternatives. Once a drug using identity is ascribed, no matter how much progress, it became clear that it is extremely difficult, if not impossible, to overcome the hostile levels of discrimination.

The 200 drug users from across Merseyside involved 134 men and 66 women. The average age was 26 years old and the most common period for drug use was between 7-13 years. In respect of their drug status 18% said they were currently drug free while a further 58% defined themselves as stable and in control. Most of the sample identified heroin as the drug they were most dependent upon. Just over half had no qualifications whatsoever, and all apart from two people were currently unemployed. 1 in 7 had never had an 'official' job at any point in their life. This discarded working class group had few legitimate options available to them and for many drug taking was an alternative to unemployment, boredom and monotony, as one person stated; *'No prospects for someone like me I gave up years ago thinking I could get a job, I might as well reach for the moon'.* Many felt that a drug centred existence was all that was available to them, recognising that it offers an all consuming alternative, with each day, and every day involving the same demanding routine:

a) The person wakes up anxious; concerned about generating sufficient funds to pay for their drug habit and stave off the onset of withdrawal symptoms. For a heroin user around £50 worth of heroin is normally required to get them 'sorted'.
b) Without access to opiates they will soon experience withdrawal symptoms of sickness, stomach cramps, aches, pains and sweating, referred to as 'turkeying'. The first signs are usually experienced soon after the person wakes up.
c) The person then has to set about making plans for the day ahead providing them with a focus, these plans are almost entirely centred around activities that will generate sufficient funds to enable heroin to be purchased.
d) The person then goes out 'grafting', (committing crime). Any goods stolen will need to be worth considerably more than the cost of the heroin they need to purchase, as they will need to be sold quickly.
e) The stolen goods are sold at a fraction of their true value, often to people living in impoverished communities.
f) With cash in hand after what might be considered a 'hard days work', the person seeks to purchase some decent quality heroin, this is referred to as going to 'score'.
g) Once they have acquired a 'wrap' of heroin they find a safe place to enjoy the 'reward' for their hard work, hoping that what they have bought is indeed heroin and doesn't contain any dangerous impurities.

h) At the end of this they can then find some rest or sleep only to begin the same routine for another day – everyday.

This isolating existence appears to have had a deep and intrusive impact on the self esteem of dependent drug users. When asked how they feel about being with people who aren't drug users, many expressed feelings of unworthy, feeling of being second class citizens;

> *'They look down on me as scum of the earth and as someone not to be associated with',*
>
> *'most people look down their noses at me',*
>
> *'they see me as a drug addict, a smackhead and they think I'd rob them'*
>
> *'some people think you are scum'*.

In addition other drug users comments illustrated a growing sense of unease and anxiety emerging;

> *'I feel beneath them, they make you feel like that', 'I feel the odd one out, I've nothing in common with them. I start to get paranoid.',*
>
> *'I used to avoid them like the plague. I used to be scared of what they might think.'*
>
> *'I feel nervous in case I slip up, I know they would look at me in disgust'.*

This fear of rejection has led to some drug users feeling they cannot risk being honest;

> *'I feel I have to make up for being on drugs. I have to be at my best, I don't want people to look down on me so I make everything look perfect.'*

This isolation and exclusion perpetuates drug use preventing and hindering opportunities for social reintegration;

> *'I never really mixed with people who have never taken drugs*.'

When asked about the quality of their relationships many drug users had little or no relationships that they would describe as friendships. Instead, they referred to having acquaintances with drug associates that were largely functional;

> *'I had drug associates and only one friend really'.*

This lonely and dehumanising experience ultimately undermines their ability to form relationships and tends to reinforce social isolation and subsequent dislocation. The harsh and demanding drug centred lifestyle is for many, all that is on offer. In the 'normal' world from which they have been excluded many feel vulnerable and lack confidence, and thus the cycle is perpetuated. When asked about why they used drugs it was clear that some used drugs to mask this sense of inadequacy;

> *'I'd use drugs to give me confidence.'*
>
> *'One of the reasons I use is that I get confidence but it's a false confidence.'*

The war on drugs has failed to recognise the structural factors that have left large sections of society socially and economically stranded. Drug users are portrayed as callous criminals who have little regard for others. However, when asked about their involvement in crime many only committed crimes to support their drug addiction:

> *'I'm not a thief, I'm not a robber, it's because of the drugs and my situation.'*
>
> *'I was using street drugs and I had to find money to support my habit.'*

Many who were maintained on methadone or were drug free had managed to remove themselves from the criminal scene altogether;

> *'Now that I'm on a script I'm not offending, it was only ever to support my habit.'*
>
> *'I'm not using so I don't need to find money.'*

The underlying factors that create the climate for problematic (not recreational) drug use tend to be structural and drug use remains much higher in poor neighbourhoods (Foster 2000). Rarely are such factors addressed, indeed treatment agencies are often poorly resourced and dogged by long waiting lists. While millions of UK pounds are spent on drug enforcement, little is allocated to treatment and rehabilitation. A staggering 85% of the UK drug budget is spent upon prevention, prohibition and punishment (European Monitoring Centre For Drugs And Drug Addiction 1997:319) and although the balance is beginning to shift amidst recognition that treatment is under resourced, it will be a long time before a more appropriate balance is achieved. Resources to assist drug users need to be more robust. Although a small proportion of drug users don't want to change their situation, it was clear from these three research studies that many became depressed, tired and frustrated, trapped within a drug centred life, wanting help to change, but seeing so no realistic options available to them.

In the Bootle study (Buchanan & Young 1996) designed to identify the needs of local dependent drug users, when asked to identify the main difficulties they faced as drug users, low self esteem and poor confidence featured as a major factor (64% of respondents) followed closely by finances and relationship issues. Surprisingly, legal and health issues scored lowest. The qualitative data revealed that confidence and self esteem are seen by drug users as a crucial factors for recovery;

> *'it doesn't matter about anything else, if you don't have confidence',*
>
> *'I need my self esteem back, it just affects everything'*
>
> *'with confidence you've more chance of carrying things out'*.

The action research of the Structured Day Programme 'Transit' (Buchanan & Young 1998a) findings highlighted the importance of social rehabilitation and the need to ensure core social work values inform practice. When asked about the staff at the Structured Day Programme drug users identified developing trust and being non-judgemental as key factors;

> *'Most of them [the staff] I got on with. It surprised me. I don't normally trust people.*
>
> *They're non judgmental'.*
>
> *'They've all been sound and approachable'.*

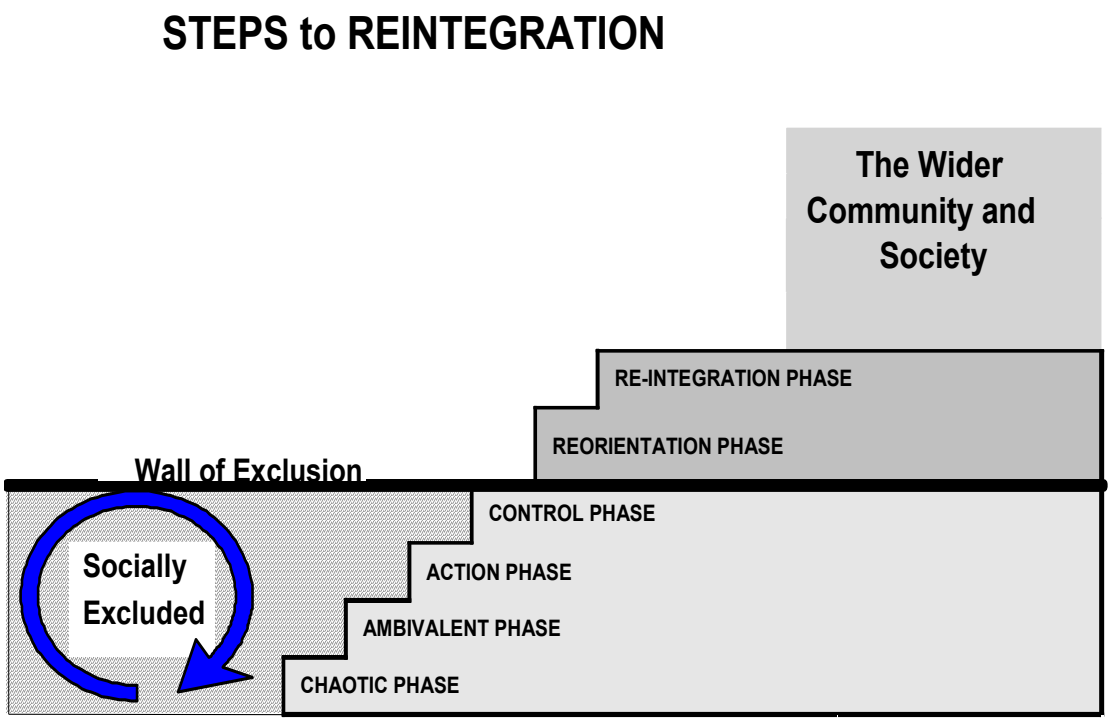
A common theme that emerged from the drug users was that many felt inferior and undeserving. The following comments illustrate the extent to which some drug users have internalised an identity as undeserving second class citizens

'We're very lucky to have somewhere like this and to be treated like equals',

'I didn't rate myself doing anything before, this has given me hope'.

The Development of a New Conceptual Framework

Contrary to discourses that have emphasised the importance of addressing physiological and psychological aspects of drug dependence, these findings suggest that the social dimension to drug use must be acknowledged, understood and integrated into policies and practices if rehabilitation and reintegration are to become realistic and achievable goals for long term problem drug users. The stage orientated model developed by Prochaska & DiClemente (1982) based originally on helping cigarette smokers give up, has proved extremely effective in helping understand the distinct stages of dependent behaviour. Significantly the identification of the 'appropriate phase' has enabled drug workers to adopt the most effective and suitable intervention (Barber 1995). Commonly referred to as the 'cycle for change' it has with good reason, dominated UK theory and practice with drug users. Paradoxically, the model has led to a risk that drug workers pathologise clients' drug problems, by concentrating upon individual motivation and psychological strategies for change. These are helpful and important factors but the social context and structural realities faced by problem drug users need to be incorporated. The Steps to Reintegration attempts to conceptualise the experiences of the drug users involved in the three Merseyside studies, and it seeks to integrate the psychological and the structural:



Each phase is discrete and drug users will tend to work their way up the steps one at a time. Some may remain on one step for a long time others for a short period. It is also possible for leaps (missing steps out) to be made upward or downward, though the latter is much more common that the

former. Recognising where a drug user is on the steps is crucial as it enables a more appropriate response to be made. Accurate assessment of motivation is often hindered by subtle coercive pressure from agency staff for the drug user to agree to a particular treatment regime. The diagram offers an alternative explanation to the long accepted chronically relapsing nature of drug dependence. Rather than it being the result of psychological dependence, craving or physical addiction, the Steps to Reintegration model suggests it is social exclusion and discrimination that are major factors leading to relapse. Once progress is made and drug users gain control it is this often-impenetrable 'wall of exclusion' that separates and prevents drug users from re-entering and participating in society. In the three Merseyside studies 76% of the drug users described themselves as either drug free or stable and in control, yet the common experience was that they felt stranded and isolated with a drug sub culture, afraid of being with the non drug using population, unable to break through the wall of exclusion.

Significantly, the vast majority of services for drug users operate below the wall of exclusion, helping drug users to regain control or become drug free. There are in the UK only a limited number of drug agencies primarily concerned with the reorientation and social reintegration of drug users into mainstream society. Some mainstream agencies concerned with social inclusion do have this role, though their remit is not specifically to assist drug users. However, it is not uncommon for drug users attending such agencies to be treated with suspicion, caution and unease.

Individual Stages to Integration

At the ***chaotic phase*** problem drug users do not see that they have a problem with drugs, and if they do they are usually unwilling or unable to contemplate change. This stage is often typified by an all consuming drug centred existence in which satisfying the need or craving for drugs can override most other issues or concerns. At this stage dependent drug users are unlikely to be able to respond to well-meaning advice, guidance or coercion. Attempts to persuade drug users of the genuine harm or risks they face are usually met with avoidance or with a passive outward acceptance countered by an inward hidden rejection. What is particularly important at this stage is to develop an honest and accepting relationship that gives the drug user permission to communicate what their intentions are in relation to drugs, without the fear of rejection or moralising from the agency worker. Within this relationship it is then possible to offer realistic strategies that may reduce the degree of risk or harm to the drug users, their family or wider community. This could include; accurate information about the risk and effects of drugs, access to clean needles, substitute prescribing on a daily pick-up basis, improvements of injecting technique etc.

At the ***ambivalent phase*** the dependent drug user is periodically beginning to acknowledge negative aspects of being dependent on drugs and these feelings cause shifts in their motivation when s/he is contemplating making changes. It would be a mistake at such times, to try and capture one of these moments and exploit the opportunity to the full. This tends to result in a coerced drug user who may initially value the attention and help, obligingly agree to treatment, but soon relapses and then feels guilty for letting the worker down. This is classically referred to 'setting the drug user up to fail'. When this happens the drug users' confidence and self-esteem can be further damaged as well as their relationship with the worker whom they may feel they have disappointed and let down. The emphasis required at this stage is to enable the drug user to explore the pros and cons of their pattern of drug use and lifestyle in general. The worker needs to avoid projecting their own personal/professional thinking, values, choices or interpretations, but instead facilitate space for the drug user to explore these issues from *their* perspective. The tension of competing priorities as determined by the individual drug user is much more likely to trigger internal motivation for change, than arguments presented by the worker.

At the ***action phase*** the dependent drug user has already decided what s/he wants to do, and is beginning to make preparations for when and how to commence different stages and where to receive additional support. Action does not necessarily mean a decision to become drug free; for example, it could be a decision to move from injecting heroin to smoking it. Most problem drug users are likely to have been dependent for many years, and will already have had a number of unsuccessful attempts to regain control of their drug habit. It is important therefore, at this phase, that the person pursues assistance appropriate to their need and situation, and at a pace of change that is realistic and manageable. Mistakes can be made either by the drug user or the worker, rushing, enforcing or pushing change. Anxious to achieve and seize the moment, this sometimes leads to poor planning, such as rushing to the first Drug Rehabilitation Centre that has vacancies rather than carefully considering the most suitable one. Good planning and preparation is crucial, this needs to include viable alternatives to fill any vacuum left by the departure from a busy drug centred lifestyle.

The ***control phase*** refers to that period when the dependent drug user has taken the planned action and has successfully regained control of their drug use. This is a time of change and uncertainty for the drug user; they need to begin thinking ahead to what new habits and interests are going to replace the old ones. It is likely too, as the above extracts indicate, that they may be quite apprehensive about the idea of mixing with non-drug users. If their long-term goal is to become completely abstinent they may be worried about meeting old acquaintances or about the onset of unexpected craving. This is a vulnerable period in which the drug user can swing between confidence about staying in control and unpredictable anxiety about possible relapse. It is helpful at this stage to explore and rehearse both the drug users' and agency workers' response to relapse, and to seek to learn positively from it, if or when it occurs. It can be misleading at this stage for the drug user to think that they have resolved their difficulties because they are now in control of their drug consumption, however, as illustrated earlier the difficulties problem drug users face go beyond physical and psychological dependence. Lifestyle, friendships, daily routines, confidence, self-esteem, health, education and employment are all issues that will need careful consideration. The likelihood of successful transition will depend heavily upon the drug users' opportunity to move away from a drug centred existence and begin to establish alternative routines and patterns.

The **Wall of Exclusion** is not a phase but a barrier that makes it extremely difficult for recovering drug users to become accepted into the structures and networks of everyday life. The propaganda designed to deter people from trying illegal drugs by portraying drug users as a deviant enemy, has led to a war on drug users themselves. This has resulted in discrimination at every level. For many drug users relapse is not attributable simply to the physical craving or a change in motivation, but as a consequence of their frustration at trying to break into mainstream community life and finding themselves constantly shunned and excluded. At the very time when recovering drug users need assistance and support from the non drug using population to establish alternative patterns of social and economic life they are often prevented by the wall of exclusion.

The ***reorientation phase*** is a particularly challenging period when the drug user is in control of their habit and trying to actively re-orientate themselves with new activities, lifestyle patterns and habits away from the drug scene. It is important at that the goals and plans here are realistic, achievable and suitable for the drug user. For many problem drug users in the research mentioned earlier, sleeping patterns, finance, education, employment, fitness, diet and friendship networks had all been seriously undermined. For some this had become a chronic problem:

> *'I go to bed at 10.30pm and can wake up at 3am and not get back. It can happen at least twice a week, I'm fucked and it pisses me off'*

'Before methadone I couldn't sleep til dawn. I was so tired it was terrible, my mind would be whirring round I just wanted to turn it off'

'I am not eating regular meals it depends upon my frame of mind as to if I buy food or drugs first'

'I snacked on crisps and shite'

'I'm underweight I'm 8st 3lbs – I should be 9stone'

Confidence and self-esteem are likely to be damaged leaving the drug user vulnerable and in need of regular support and encouragement. Many drug users felt uneasy and threatened in the company of non-drug users, yet this is the group of people whose support, friendship and integration is crucial. Sheltered environments specifically designed to assist drug users such as Structured Day Programmes, day centres, befriending or buddying schemes are useful at this stage, but such services are scarce. For a drug user who hasn't eaten three meals a day or slept through the night for the past 6 years (and this wasn't unusual in our studies), the reorientation phase can take a significant amount of time.

The ***reintegration phase*** is the period when the dependent drug users begin to participate and join in mainstream activities. Due to negative experiences, many drug users feel anxious and afraid of judgmental attitudes from non drug using population, and understandably tend to lack confidence. Normal day to day activities such as engaging in further education, doing voluntary work, attending school meeting, doing a vocational adult education course, joining the local gym can be very intimidating as many have been disconnected from mainstream activities. They face a dilemma of whether to disclose their drug history, knowing that, ironically, honesty is likely to lead to distrust and possible discrimination. Acceptance and belonging within non drug using communities will enable the drug user to complete the break from a drug centred lifestyle. Unless 'doors open' and drug users are sufficiently integrated and purposefully occupied it will be hard to sustain, and the risk of relapse looms. This reintegration phase is crucial if the drug user is to successfully make the transition and participate in the social and economic life of her/his local community.

Conclusion

This paper has argued that the key issues that drug users face are related to discrimination, isolation and powerlessness. Those drug users, who become long-term and dependent, tend to have been disadvantaged and socially excluded from an early age prior to their taking drugs. For many of these people an all-consuming drug centred lifestyle was not the problem, but a solution to a problem. Social work has a long standing tradition of highlighting injustice, discrimination and inequality, and seeking to empower the service user. Social workers are then, ideally placed to make a significant contribution to draw attention and develop increasing awareness and understanding to the issues of oppression and discrimination that many drug users experience. This is not to suggest that some drug users don't warrant adverse reactions, but it is to argue that blanket discrimination is unacceptable. Drug users deserve to be treated as individuals. Rarely has this happened and many drug users have internalised the ascribed negative identities which have only served to further damage their self worth, and hinder their progress.

The Social work values (www.basw.co.uk) of human rights, empowerment, respect for diversity, respect for the person, fair access to public services, equal treatment, self-determination are particularly relevant when working with drug users. When agency staff have worked to these values drug users have noticed the difference and spoken positively of these workers. If the drugs 'problem'

is going to be successfully tackled then the wall of exclusion, - which is partly constructed and maintained through tabloid shock horror campaigns and populist government propaganda, will need removing. The emphasis on individually pathologising the drug problem through physiological approaches enforced through drug testing or cognitive behavioural programmes as a condition of Probation Orders needs to be balanced by strategies and services for drug users that acknowledge the present day social context. The structural dimension to drug dependence must be understood and tackled if genuine progress is to be achieved. The model of Steps to Reintegration model offers an alternative paradigm that conceptualises the notion of discrimination and exclusion. It also enables social work to begin to focus attention upon addressing the gap in the services by promoting structured day programmes, day centres, befriending schemes and sheltered workshops can play.

Challenging discrimination is part of the social workers commitment to Anti-Discriminatory Practice. It is perhaps easier to deliver when society more readily understands and accepts the issues involved, for example, combating discrimination that is directed at older people or the discrimination directed at people with disabilities. However, challenging discrimination towards drug users attracts little support or sympathy. But then challenging racism or sexism 50 years ago may not have gained much support or sympathy either.

Acknowledgement
I am indebted to Lee Young whose many hours of discussion and rigorous analyse helped to shape and develop the thinking behind this paper, and to colleagues at University of Wales, Wrecsam for their help and advice.

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This paper was published in the Journal of Social Work in Mental in Health:

Buchanan J (2004) Tackling Problem Drug Use: A New Conceptual Framework, pp117-138, in Social Work in Mental in Health, Vol. 2 No 2/3, Haworth press