A FRAMEWORK FOR UNDERSTANDING DRUG USE

'Disease' models have been replaced by more realistic but more complex concepts. This three triangles framework is one practical way to organise the confusion.

Andy Malinowski

THE TERM "Problem drug taker" was introduced by the Advisory Council on the Misuse of Drugs in their 1982 *Treatment and rehabilitation* report, defined as:

"any person who experiences social, psychological, physical or legal problems related to intoxication and/or regular excessive consumption and/or dependence as a consequence of his own use of drugs or other chemical substances (excluding alcohol and tobacco)".

However, this more comprehensive new drug related problems approach requires a clear framework within which to make sense of information and events. Without this, attempts at assessment may become bogged down by the diversity of input, leading to further loss of confidence and yet more confusion.

Together with the three triangles framework suggested here, readers may wish to make use of the assessment guidelines in the *Working with drug users* video training pack (available from ISDD). The framework developed here is based primarily on the ideas and writings of Les Kay and Rowdy Yates, to whom I am indebted.[1]

Implicit throughout this paper is the rejection of the myth that only 'specialists' can deal with problem drug users, and the suggestion that, with adequate information and training, generic workers are able to respond appropriately.

TYPES OF DRUG USE can be classified as either experimental, recreational or dependent (see first triangle in diagram).

► The term 'experimental' refers to drug use in the very early stages of contact with the drug. This type of drug use is *irregular*, in the sense that it does not conform to any pattern, and the choice of substance is often *indiscriminate*, depending on factors such as availability, reputation, subculture, fashion and peer group influence. Situational factors such as time of day, company and setting are largely irrelevant to the choice of drug or the quality of the experience, and may simply reflect chance, curiosity, or coincidence, rather than design. Experimental drug use may be a group or an individual activity, and may develop in to recreational drug use, or simply stop. Form of administration varies and may include injecting.

Taking a drug at a party for the first few times would come under this category, especially where there was some conscious exploration/anticipation of its effects.

► The term 'recreational' refers to a form of drug use in which hedonism is prominent. Without condoning the activity, the term acknowledges that for most drug users anticipated pleasurable effects are the prime motivation.

Recreational drug use is usually *discriminatory* in the type of drug used and the situation chosen for that use. Drug choice is influenced by availability, experience of experimentation, personal taste, expectations, resources and social and cultural factors. The decision to use the drug and the quality of the experience are related to situational factors such as time, company, resources and setting.

Recreational drug use is characteristically *regular* but *controlled*, usually taking place in a social group and meeting a variety of individual and group needs. Injecting would usually be excluded. Whether legal or illegal, recreational drug use is to some extent a 'normative' activity, conforming to various social and subcultural rules and expectations. The setting may vary from a pub to a friend's house, depending among other things on the legality of the drug. Enjoyment, pleasure and sociability would be a prime expectation in this scenario.

► Drug use characterised by physical and/or psychological dependence is distinguished from the preceding types by being more *frequent* (often involving use several times a day), *less controlled* but nevertheless *regular*. Obtaining the drug is more important to the user than its quality or the quality of experience. Situational factors such as time, company and setting are therefore secondary. Injecting is common.

Dependent drug use is usually a solitary or small group practice, displacing rather than complementing social activities. It can be seen as a way of coping with stress and does not inevitably develop in response to the pharmacological effects of the drug.

PROBLEMS AND ISSUES related to drugs can be classified under the headings health and safety, lifestyle and management.

► With more physically toxic substances, *amount* taken over a given period may be crucial to the health and safety outcome.

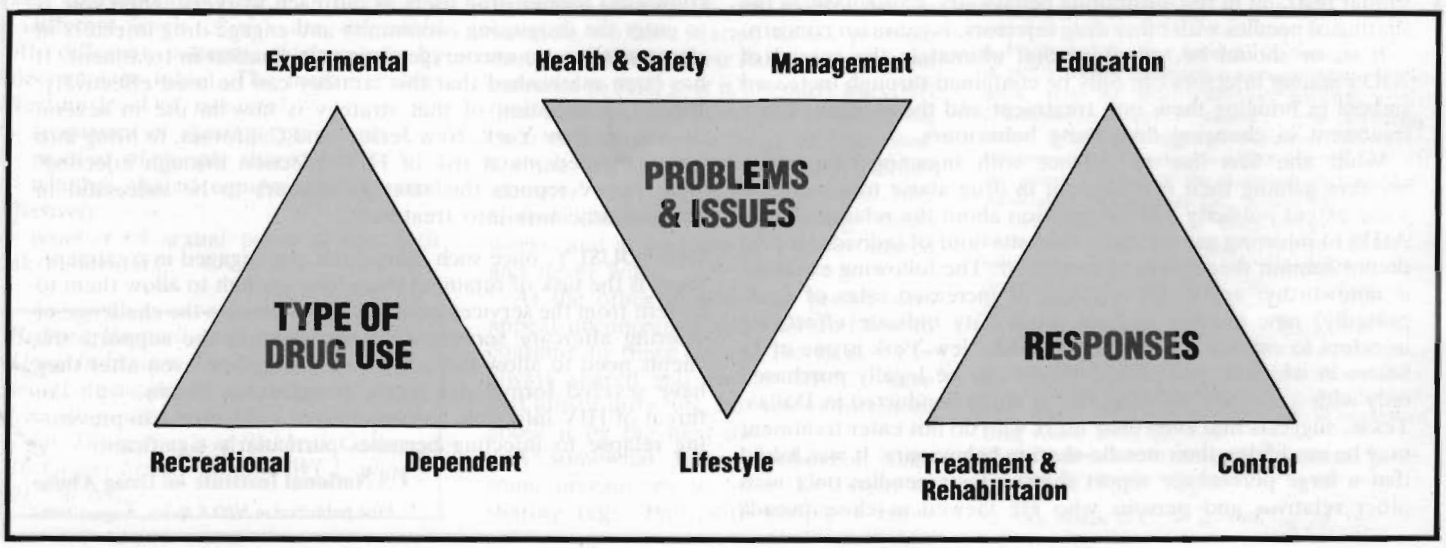
Form of administration can also directly contribute to health and safety problems. For example, injecting rather than smoking heroin risks infection, abscesses, thrombophlebitis, gangrene, septicaemia, hepatitis B and AIDS.

Operating machinery or driving while intoxicated, or being in a *situation* where balance is important, increases the risks.

Lastly, the *frequency* and *duration* of drug use can contribute to phsyiological damage. For example, both alcohol and tobacco used heavily and frequently over a prolonged period may lead respectively to respiratory problems and liver disease. Apart from increasing health risks, frequency of use contributes directly to the development of tolerance and physical dependence.

In practice, all these variables will need to be considered as a related whole.

The author is project leader of the Druglink drug advisory centre, 174 Victoria Road, Swindon, Wiltshire, SN1 3DF, phone 0793 610133.



► Lifestyle problems and issues are specific to the individual user as a member of the wider society, rather than directly related to the drug or its pattern of use. They may *precede* drug use and contribute to its development, or *succeed* and be the result of drug use. Often they are a combination of the two.

An example of the first would be a rootless person lacking confidence and resources, whose dependent drug use becomes a response to their painful situation. An example of the second would be an individual facing criminalisation due to being found with cannabis or other drugs.

Lifestyle problems can be related to wider structural (or *macro*) situations beyond the direct influence of the individual (level of housing stock, provision of education, employment, etc) or to *micro*-level events and circumstances directly affecting the individual and theoretically more open to their influence (eg, personal relationships, day-to-day living).

Distinguishing between the macro and micro context serves two functions. First, it clarifies discussion of the degree of individual versus social responsibility for the client's present drug use, helpful where individuals blame themselves for their predicament, leading to a further deterioration in confidence and self-esteem. Secondly, an analysis of this kind may provide pointers for future change.

► Problems and issues related to management are specific to the workers and agencies responding to drug use, rather than directly related to the pattern of drug use or the individual user. These 'worker problems' derive either from the policies and structure of the agency, or arise in the course of dealing with a particular customer.

Management issues related to the structure of an agency may be *institutional* (its procedures, regulations and policies), *legal* (the need neither to condone nor to commit criminal acts), or *philosophical* (the agency's values and beliefs). Those related to the management of the customer can be *methodological*, (what to do and how and when), *emotional* (the worker's feelings or prejudices), *informational* (the worker's lack of training and education) or *medical* (eg, the risk of the worker contracting hepatitis or AIDS). Awareness of management issues in working with drug users may facilitate help and minimise inconsistency.

Management problems related to institutional structures often lead to a control response, but such responses and the rules they enforce can occasionally conflict with other institutional interests and the interests of the drug user themselves.

RESPONSES to drug problems can be considered under the headings of education, treatment and rehabilitation, and control. The choice will be determined by the type of drug use, related problems and issues, and by the limits of the responses available.

► Educational advice and information aimed at *reducing potential or actual harm* can mitigate health and safety and lifestyle problems. For example, emphasising use of clean needles and syringes to avoid infection may be the most realistic option when the user is not ready to 'come off'.

Educational responses can lead to management problems. Thus youth workers who advise dependent glue sniffers not to put large bags over their heads (which risks suffocation), may come into conflict with their management, who expect a response aimed solely at stopping the activity.

► There are various types of treatment and rehabilitation response which, according to the Advisory Council on the Misuse of Drugs, should aim:

"a. to enable problem drug takers to utilise personal resources and so modify attitudes, behaviour and skills to achieve a more stable and fulfilling way of life with minimal or no drug related problems;

"b. to provide the social supports and agencies required to facilitate the development of the individual so as to establish or re-establish problem drug takers in the community in roles which they find more stable and fulfilling than those related to their previous drug use."

Whether a treatment and rehabilitation response is appropriate will depend on the type of drug use and on related health and lifestyle problems. Psycho-analysing an experimental drug user may be totally inappropriate and counter-productive, as would referring recreational cannabis smokers to a psychiatrist (not unknown).

► Control responses aiming to *enforce social norms* or prevent socially unacceptable behaviour have direct links with management issues and problems. Such responses may vary from broad legislation (eg, Misuse of Drugs Act) to rules and expected conduct in youth clubs, hostels, schools, etc.

Occasionally control responses conflict with the interests of the drug user, leading to further complications. An example would be a school calling in the police because a pupil was found with an illegal drug, creating a legal lifestyle problem for the pupil and probably also future management problems for the school in their relations with the pupil.

An example of conflict between control and treatment and rehabilitation responses is the refusal of some residential therapeutic communities to admit drug users not drug free for 24 hours. The communities may retain their structure intact, but may also frustrate attempts to 'come off'.

Control responses can affect health problems and issues: restrictive prescribing policies designed to reduce access to legal drugs may result in an increased use of illegal drugs, while a clampdown on the availability of needles and syringes to prevent injecting, may lead to increased sharing and medical complications.

POTENTIALLY each variable in the framework can interact with each of the others: as the *type of drug* use changes so do related *problems* and appropriate *responses*. An *educational response* may reduce *health and safety* problems which may alter *management* issues, and so on. In practice, the framework can be applied to assessment in the following way.

- First, by establishing the *type of drug use* through questions such as: How regular is it? Does it conform to any pattern? Is the type of drug important? What motivates the drug use? Is time, company and setting relevant? Is it controlled?
- Answers to such questions will also indicate the relationship between the drug taking activity and preceding/succeeding *problems and issues*, more fully ascertained by focusing on health and safety and lifestyle issues.
- Questions about the form of administration, its circumstances, and its frequency will indicate the need for *medical care*, such as detoxification or the treatment of abscesses, septicaemia, etc. Questions about lifestyle in relationship to drug use may give us an understanding of its *significance*, eg, is the drug use hedonistic, or a response to stress?
- This information in turn may generate *management* problems and issues as we decide on an appropriate *response*.

THE DRUG USER's participation is the pivot of the framework in practice. The model should be applied *dynamically* as the situation changes or in response to differences between drug users, assessment and response being based on *interaction* between the drug user and the worker in which the user is an equal partner. Too often the user's perceptions, wishes, and self-defined needs are ignored — like at a rehabilitation house where all residents are denied visitors for the first three months, regardless of their individual strengths and weaknesses or needs and wishes. In situations like this 'assessment' is non-existent and the likelihood of the response being appropriate to the individual, is all but left to chance. □

AN EXAMPLE OF HOW MANAGEMENT AND CONTROL CAN CONFLICT

One evening a worker in a hostel for ex-offenders comes across a group of residents smoking cannabis. Following discussion they ascertain this is recreational use, indicated by the type of drug use and the situation, as well as by the residents' perceptions that for them it is a pleasurable, non-problematic activity. It appears their cannabis smoking does not stem from or give rise to immediate health or lifestyle problems, other than the illegality of the act, but hostel policy states no drugs are allowed on the premises and that violators of this ruling will be asked to leave — creating a clear *management* problem with a mandatory *control* response. *Not* applying the ruling could prejudice the institution's survival and weaken the credibility of its anti-drugs stance. However, *applying* it may jeopardise any progress the residents have made (contrary to the institution's rehabilitative aims) and render them homeless (a lifestyle problem). An alternative would be to allow each infringement of the rule to be dealt with individually, making available a wider range of response options.

1. Kay L. *A UK perspective on prevention of problem drug use*. Paper presented at the 8th World Conference of Therapeutic Communities, Rome, 1985.

Kay L. *A problem focused intervention model or towards a therapy of addiction, or there's a lot of it about and do we really know what we are doing?* Lifeline Project, 1983, unpublished.

Yates R. *Addiction: an everyday 'disease'*. In: *Approaches to addiction. Research highlights in social work 10*. London: Kogan Page, 1985.