## Contents

[List of Figures and Tables] vii  
[Acknowledgements] viii  
[Preface] ix  

1 Care and Control: Drug Dependency, Health Risks and Social Harm 1  
Different types of solution for different types of problems 1  
Understanding the complexity: the example of prescribed drugs 2  
The wider picture: policy and practice in perspective 4  
Historical models of care and control of opiates 6  
Contemporary models of care and control 10  
Understanding the complexity: returning to the example of prescribed drugs 12  
Advantages and disadvantages of prescribed opiates 14  
Conclusion 15  

2 Drug Users’ Perspectives on Drug Use and Dependence 18  
Introduction 18  
Methodology for exploring user views 18  
User views of drug use and dependency 20  
Discussion 31  

3 Reducing Dependence: Approaches to Treatment 35  
Introduction 35  
Treatment: what is it and what is it for? 35  
The three perspectives 39  
Different drug treatment models: doing the same things but defining them differently? 55  
Implications for practice 64  
Additional notes 68  

4 Drug Users’ Perspectives on Health Risks 74  
Introduction 74  
Reasons for taking risks 75  
Discussion 83  

5 Harm Minimization and Public Health 86  
Introduction 86  
Harm minimization: what is it and what is it for? 86  
Understanding the problem 89
## Contents

The development of harm minimization services 91  
Health and mental health care needs 96  
Three harm minimization approaches 101  
Practical guidelines for harm minimization 108  
Conclusion: drug treatment, harm minimization or both? 114

### 6 Drug Users’ Perspectives on Social Harm 117

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>117</td>
</tr>
<tr>
<td>User views of the importance of social factors in drug use and crime</td>
<td>118</td>
</tr>
<tr>
<td>Discussion</td>
<td>128</td>
</tr>
</tbody>
</table>

### 7 Reducing Social Harm: Social Inclusion and Crime Reduction 131

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>131</td>
</tr>
<tr>
<td>The relationship between drug use, social groups and wider society</td>
<td>132</td>
</tr>
<tr>
<td>The relationship between drug use and crime</td>
<td>136</td>
</tr>
<tr>
<td>The relationship between drug use, crime and social exclusion</td>
<td>139</td>
</tr>
<tr>
<td>Is drug treatment a solution to crime problems?</td>
<td>140</td>
</tr>
<tr>
<td>Are treatment services for offenders effective?</td>
<td>142</td>
</tr>
<tr>
<td>Crime reduction</td>
<td>144</td>
</tr>
<tr>
<td>Problems of medicalizing crime and criminalizing illness</td>
<td>145</td>
</tr>
<tr>
<td>A conflict of care and control?</td>
<td>146</td>
</tr>
</tbody>
</table>

### 8 Working with Users: Motivation, Maintenance and Recovery 149

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>149</td>
</tr>
<tr>
<td>New beginnings and no end</td>
<td>151</td>
</tr>
<tr>
<td>Old generic skills and new specialist methods</td>
<td>155</td>
</tr>
<tr>
<td>Motivation to change: the process model and methods</td>
<td>159</td>
</tr>
<tr>
<td>Assessment</td>
<td>163</td>
</tr>
<tr>
<td>Care plans</td>
<td>171</td>
</tr>
<tr>
<td>The relevance of specialist theory and practice for generic professionals</td>
<td>172</td>
</tr>
<tr>
<td>Monitoring and evaluation</td>
<td>174</td>
</tr>
</tbody>
</table>

### 9 After-Care: Relapse Prevention and Social Inclusion 176

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>176</td>
</tr>
<tr>
<td>Developing psychological skills and new social networks</td>
<td>176</td>
</tr>
<tr>
<td>The psychological approach to after-care and relapse prevention</td>
<td>180</td>
</tr>
<tr>
<td>The social approach to after-care</td>
<td>186</td>
</tr>
</tbody>
</table>

References 193  
Index 227
Drug use causes three different types of problem, for which there are different solutions. In addition, drugs not only cause different types of problems for individual drug users but also for the communities they live in. Drug dependence itself can involve physiological and psychological dependence and neurological compulsion. Health-related harm can include individual health problems such as overdose and public health problems such as transmission of blood-borne diseases. Social harm can include individual problems such as social exclusion and community problems such as crime.

It is therefore difficult for any one intervention to be successful in dealing with all aspects of dependency and health and social harm to individuals and communities at the same time. For this reason it is necessary to clarify and distinguish different types of problems associated with drug use, before attempting to provide solutions in terms of care and control.

There are many different interpretations and theories of drug dependency and the health or social problems associated with drug use. These different theories result in different understandings of problems, different solutions and different definitions of success or failure. Unfortunately, each separate theory or approach can also limit the type of help offered, the length of time it is offered for and the people it is offered to.

Different types of solution for different types of problems

This book is designed to examine each type of problem, whether dependency, health related risk or social harm, and the respective solutions in terms of both care for individuals and control for communities.
### Understanding Drug Misuse

Table 1.1 Categorization of drug problems and their solutions

<table>
<thead>
<tr>
<th>Type of problem</th>
<th>Harm to individual drug user</th>
<th>Harm to wider population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependence</td>
<td>Bio-psycho-social harm</td>
<td>Socio-economic harm</td>
</tr>
<tr>
<td>Health-related harm</td>
<td>Short and long term risks to individual health</td>
<td>Transmission of blood-borne diseases (HIV, hepatitis)</td>
</tr>
<tr>
<td>Social harm</td>
<td>Social exclusion, unemployment, homelessness</td>
<td>Crime, risks to community order</td>
</tr>
</tbody>
</table>

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<tr>
<th>Different solutions</th>
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<td>Type of solution</td>
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<td>Dependence</td>
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<td>Health-related harm</td>
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<td>Social harm</td>
</tr>
</tbody>
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Table 1.1 provides a rough categorization of different types of drug problems and their respective solutions.

The table illustrates the range of different problems and solutions associated with drug use, though it should be noted that some problems and solutions do not fit neatly into one of these categories. The wide range of potential solutions has led to a series of controversies, not only because one solution can be used for different problems, but also because some interventions that provide a solution to one type of problem can make another type of problem worse.

### Understanding the complexity: the example of prescribed drugs

A brief example will be used to illustrate the complexity of drug problems. This will be followed by an overview of different types of care and control, before returning to the example in order to illustrate how
different models are implemented in practice. It should be noted that the concepts of care and control are not as clear cut as they initially appear here and can sometimes overlap or become confused.

Maintenance prescribing of heroin substitutes such as Methadone will be used as an example because this can be seen as the solution to different types of problems:

- **Dependence**
  - Voluntary maintenance treatment for drug dependence (care)
  - Coercive maintenance treatment for drug dependence (control)

- **Health-related harm**
  - Reducing health-related harm to individuals (care)
  - Reducing the spread of blood-borne diseases such as HIV, hepatitis B or C (control)

- **Social harm**
  - Reducing social exclusion (care)
  - Reducing crime (control)

Long-term Methadone prescribing can therefore be seen as a solution to a range of different problems, including dependency. However, it is controversial whether prescribing should be aimed at abstinence and recovery from dependency, or at reducing public health or social problems. Whilst maintenance prescribing is often described as ‘treatment’ it does not reduce dependency itself, in contrast it may exacerbate physiological dependency, psychological dependency and neuro-chemical compulsion, as an individual’s drug use becomes more entrenched. Long-term maintenance prescribing of substitute opiates, such as Methadone can be seen as a clinical solution to dependency, but is perhaps more often seen either as a means of reducing individual drug-related harm, a public health measure to reduce wider harm such as HIV in populations, or a controlling measure to reduce crime.

It will be apparent that the situation is complex and confusing. This example is used because it perhaps best illustrates how complicated the drugs field is for professionals trying to care for drug users and control drug use at the same time. It can be seen that an intervention aimed at controlling crime and reducing harm through long-term prescription of maintenance drugs might conflict with the need to treat physiological addiction. Harm minimization interventions can decrease the likelihood of future recovery and abstinence because substitute prescribing can contribute to increasingly entrenched, compulsive drug use and long-term addiction. Whereas, abstinence-orientated interventions can
undermine harm minimization objectives because they may increase the risk of future relapse and associated harm. Perhaps for this reason the controversy between these two approaches remains as fierce and unresolved as it was a century ago and the rationale for prescribing drugs may sometimes be unclear.

It is hoped that this example has raised a series of concerns and questions. These will be returned to at the end of this section. However in order to gain a clear overview of the complexity that underlies these controversies, it is first necessary to go back in time to get a broader overall perspective of responses to drug use over the years. In this way it will be possible to understand how drug problems became understood in terms of dependency and/or health and social harm and how solutions were developed for each type of problem.

**The wider picture: policy and practice in perspective**

Drug dependency is a disputed concept and its treatment controversial. By the same token, drug-related health and social harm encompasses both harm to the drug user and harm to the wider society. Perhaps because this is such a complex area, fashions in theory, policy and practice change rapidly, often distorted by contemporary political context. It will therefore be useful to give an overview of the range of different understandings and responses over the past hundred or so years, in order to provide a foundation for the contemporary approaches discussed in later chapters.

Overall, drug use literature has focused on physiological and psychological aspects of drug use, that is, what can be reliably assessed and measured. This has led to lack of focus on less accessible aspects of drug use such as loss of control, compulsion and craving and social factors such as relationships, social exclusion and offending. In order to gain a broad understanding it is therefore necessary to go back before medical and psychological models took precedence and envisage drug use in a more general way. The following section will give an account of beliefs and theories in the past hundred years and compare this with contemporary beliefs and theories. From this distance it will be possible to get a clear view of the overall problem, to see how little has changed and how much any one theory or policy may narrow and distort our understanding and our interventions at any one time.

Controversies in the drug field today reflect those of the late nineteenth century. A hundred or so years ago drug problems were understood largely in terms of the harm that an individual’s drug use caused
others (families or the wider community) and occasionally themselves, through compulsive use. Solutions were seen largely in terms of control of supply. However, towards the end of the nineteenth and early twentieth centuries ‘physiological addiction’ itself became the focus of attention, rather than harm caused to others, and solutions were seen largely in terms of clinical treatment. In the late twentieth century the health-related harm caused to drug users and others, through transmission of HIV and hepatitis, became the focus of public health interventions and solutions were again seen largely in terms of public health and health-care interventions. In the early twenty-first century the harm caused to others (through drug-related crime) has once again become the main focus and solutions are seen in terms of control of supply and control of individuals.

Contemporary research literature in the drug-use field has reflected these changes in attitudes, moving from treatment models of addiction and dependency towards models of harm minimization and crime prevention based on public health and social understandings of drug use respectively.

Drug use has always been controversial and has often become a political issue. There has seldom been agreement about what constitutes a drug problem or what constitutes an effective solution. Consequently there have been continuing conflicts between drug users themselves, academic theorists, treatment providers and politicians. The various theoretical models have included a moral model; a spiritual disease model; a medical disease model; a cognitive/behavioural model; a social deprivation model; a public health model and a neuroscience model. Different types of theory or model are associated with different policy and practice at various points in history. However, all these approaches remain active today though they may be seen as mutually exclusive rather than as describing different phenomena associated with drug use.

It is possible that the effects of drug use on the human physiology and psyche reflect or accentuate normal individual or social processes. If this were so, it would be sensible to see drug use in the context of human nature as a whole, rather than as a separate and distinct problem. Beliefs about drug use through the ages have been, to some extent, a reflection of wider beliefs about human nature held by particular groups, whether religious, moral, academic or professional. So for example, the moral and religious models of the nineteenth century were based within the context of beliefs about human nature and the soul: these were followed in the twentieth century by medical and clinical models, based on newly developing professional beliefs about human nature and the psyche. It is possible that future models for the twenty-first century
may reflect new advances in neuroscience and potential models of human nature based on the significance of brain chemistry.

It is clear that medical and psychological models have had limited success. Despite the fact that medical and disease models of physiological addiction were developed more than a hundred years ago, it has proved very difficult to demonstrate that drug treatment is effective or that any one type of treatment is more effective than another. As a consequence these treatment models have come increasing under scrutiny and the approaches adopted in pre-clinical times considered again today. For example, as neuroscience develops it is likely that a sophisticated understanding of the chemistry of the brain will shed new light on how drugs affect social (and perhaps moral) functioning and why some drug use becomes compulsive and intractable for some individuals without necessarily being physiologically addictive (Moos, 2007, 2008; Morganstern and McKay, 2007; Marlatt, 1996).

In order to shed light on the complexity of contemporary models and solutions, a series of historical models will be briefly outlined in terms of their aims and objectives. These will be set out in chronological order, examining how nineteenth century theories of the social causes and consequences of drug use, and ideas about spiritual and moral degeneration, were replaced by medical and psychological models of the twentieth century only to be revived again in the twenty-first century.

**Historical models of care and control of opiates**

Theories of physiological addiction were not developed in Britain until doctors began to become interested in these phenomena, in association with opiate use, at the turn of the nineteenth century. Prior to this, for example, little medical interest had been taken in opium use. Instead it was often understood as useful for individual health if used safely in moderation and as a social or moral problem if used compulsively or excessively.

The following section will briefly outline each of these traditional approaches to opiate use in chronological order and show how each contributes to contemporary practice alongside the newer disciplines of psychology and neuroscience. It will become apparent that social problems were the first to be identified, followed by health-related harm, with notions of dependency and treatment only developing in the past hundred or so years. These problems are dealt with in reverse order later in the book in order to reflect the contemporary emphasis on dependency, not because dependency is necessarily more important.
• **Problems and solutions to social harm**
  Reducing social harm to individual users
  Reducing social or moral harm to populations

• **Problems and solutions to health-related harm**
  Reducing health-related harm to individual users
  Reducing public health-related harm to populations

• **Problems and solutions to dependency**
  Dependency and treatment

Reducing social harm to individuals: the social model

Berridge and Stanton (1999), Berridge and Edwards (1981) and Harding (1988) give the most detailed accounts of the extent of opiate use in the nineteenth century. They conclude that in the early part of the nineteenth century ‘working-class opium eating’ was commonplace, stating that the equivalent of 600mg per head was consumed each year in 1827 and that this increased to three-and-a-half times as much in 1859. This opium was used for many minor ailments as well as more serious illnesses and was sold widely by chemists, shop-keepers and travelling salesmen (Anderson and Berridge, 2000). It is interesting that whilst alcohol was often seen as a cause of social evils, excessive opiate use was often seen as a consequence. Harding (1988) states that opium eating was ‘regarded at worst as a minor vice or a bad habit’ continuing, ‘the use of opium imported into Britain continued along with an essentially relaxed attitude to its consumption for much of the early 19th Century’. At this time ‘working class consumption was attributed to poor housing conditions and fever epidemics’ (quoted by Harding from parliamentary paper, Report to the Commissioners for Inquiring into the State of Large Towns and Populous Districts: XVIII, 1844.) ‘While its consumption by the middle classes was held to result from their experience of pressure from severe mental distress.’ (quoted by Harding from ‘Medicus, Teetotalism and Opium Taking’, *Lancet*, 1851: 694). These beliefs underpinned the thinking of a large section of the population, known as opium apologists and are not dissimilar to some social theorists today (see Chapter 7).

Reducing social harm in populations: the moral model

Despite the political tolerance of opiate use, the first attempts to control the use of opiates by the Society for the Suppression of the Opium Trade (founded in 1874) influenced the control of drug use over the
following decades. In contrast to the opium apologists who utilized a social model of drug use, these organizations proposed that drug use was the cause rather than the consequence of social evil. They (and the newly formed Temperance groups) believed that any drug use changed natural human functioning for the worse and as a consequence they opposed the idea of the free trade in drugs and drink respectively (Berridge, 1999).

The Society for the Suppression of the Opium Trade (SSOT, was founded by the Quakers and the ideas are therefore based on Quaker religious and moral beliefs, not merely about the nature of drug use, but also of the nature of man and morality. Essentially the SSOT believed opium use to have ‘the property of impairing the habitual user, not just physically, but also morally… opium dependence was seen as a “vice” caused by a pathologically debilitated will and pathologically impaired moral faculty’ (Harding 1988). The beliefs of the Quakers and SSOT corresponded closely to those held by the early religious groups attempting to deal with alcoholism (for example, The Oxford Group) and with those held by the founders of Alcoholics Anonymous in America. They also correspond with the beliefs held by many laymen and professionals who have contact with the Narcotics Anonymous Fellowship in Britain today, and are still well integrated into the contemporary American approach to drug policy and treatment. These beliefs about impaired moral and social functioning may also be reflected in the findings of modern neuroscience concerning the effects of drugs on decision making and impulse control (see Chapter 3).

Reducing health-related harm to individuals: the harm reduction model

The Poisons and Pharmacy Act of 1868 was the first to attempt to regulate opium use in the general population. The problem facing the Government at this time was not complicated by notions of addictive disease or moral deterioration, it was simply an issue of how to regulate the sale of opiates in order to reduce ‘poisonings’, that is, to reduce accidental deaths by overdose and suicide. This new area became a monopoly of professional pharmacists in the early twentieth century and was an important factor in the establishment of the pharmaceutical profession. ‘Even the minimal safeguard of labelling each opiate dispensed as a poison was sufficient to produce a 26 per cent decline in the mortality rate at the start of the twentieth century. The more substantial regulation of opiates after 1908 brought about a further decline of 20 per cent (Parssinen, 1983: 75). This is reflected in the contemporary society where UK pharmacists can dispense opiates
in a controlled way with increasing powers to prescribe independently of doctors: similarly in France a partial opiate agonist/antagonist (Subutex) can be sold over the counter in pharmacies (see Chapter 5).

Reducing health-related harm in populations: public health model

Early public health legislators lobbying for general health and safety measures were concerned with developing laws to control the widespread use of opium in the population as a whole. This group were often in conflict with doctors and it was this group, rather than medical practitioners, that was responsible for its eventual decline in the late nineteenth and early twentieth centuries (Anderson and Berridge, 2000). This situation again reflects a contemporary conflict between public health professionals who advocate harm minimization and clinicians who advocate treatment and abstinence. The public health model of this time is perhaps most clearly correlated with the public health and harm minimization approaches of today where reducing health-related harm is the main objective and information and education are the main methods (Berridge, 1999) (see Chapter 5).

Reducing addiction, dependency and compulsion: the medical and disease models

The early twentieth century models of addiction incorporated three distinct phenomena; physiological addiction, psychological dependence and compulsion. In contrast with the public health campaigners and pharmacists, the medical profession was less concerned with the general consumption of opiates but specifically with the therapeutic morphia addicts. That is, with physiological addiction itself rather than simply entrenched use, risky use or compulsive behaviour.

The earliest medical theory was formulated by Levinstein in Morbid Craving for Morphia (1878) where he describes this new disease, ‘the uncontrollable desire of a person to use morphia as a stimulant and a tonic, and the diseased state of the system caused by the injudicious use of the said remedy’ (quoted in Parssinen, 1983: 86). It can be seen that this initial approach identified two phenomena, distinguishing between compulsion and its physiological consequences. This was followed by work by Dr Kerr, who proposed a third phenomenon associated with addiction, psychological dependence. In an early text of this time Inebriety or Narcomania: Its Etiology, Pathology, Treatment and Jurisprudence, Kerr (1894) modified Levinstein’s conception of the disease of addiction by stressing that it had a psychological aetiology
and by emphasizing the difficulty of reversing a patient’s opium habit once it was fully established. These three themes became prominent in the twentieth century literature on dependence and addiction (see Chapter 3).

The concept of entrenched use existed separately and prior to the notion of physical addiction. It is significant that medical interest in opiate use and physiological addiction only developed when morphia began to be prescribed in an injectable form soon after the hypodermic syringe was invented in the second half of the nineteenth century. Morphia was used in much greater concentrations than the opium commonly sold prior to that time and physiological dependency and withdrawal symptoms were therefore more likely to be identified. Morphia was initially available as a medical treatment for pain and various illnesses, but there was no restriction on its sale until the 1920s. Patients received the type of repeat prescriptions that remained their property and could be refilled continually, allowing the user to continue use after its ‘medical use’ for as long as they wished. Doctors focused on the minority of therapeutic morphia addicts after the Rolleston Committee of 1924 (which was largely composed of doctors) reinforced the notion of drug use as a disease and therefore clearly within the remit of doctors. The problem was seen as a purely medical concern defined in terms of physical disease rather than in terms of morality and social control, though with little understanding of its cause, as no organic source of addiction had been discovered (Harding, 1988). In this way the medical model of physiological addiction was born, defining addiction in terms only of its effects on the functioning of the body, with little interest in its effects on the social, psychological or moral functioning of individuals. Nevertheless, opiates could now be prescribed, under certain conditions determined by the doctor, on a maintenance basis. The Rolleston Report laid the guidelines for drug policy in Britain for much of the twentieth century, and it can be seen as defining what came to be known as ‘the British system’ of substitute prescribing for addicted patients.

Contemporary models of care and control

Current controversies reflect those of the previous centuries. Those advocating treatment argue about whether the problem is best understood as addiction, dependency or compulsion and whether the solutions should be abstinence or maintenance. Those advocating social or public-health approaches argue about whether the problem is best understood as a consequence of deprivation or a moral decline and
whether the solution should be to help individuals to cope or to attempt to control their behaviour.

Contemporary authors such as Ashton (2008), McKeganey (2007), Stimson (2007), Simpson (2004), Warner-Smith et al. (2001), Preble and Casey (1998), Granfield and Cloud (1996), argue either for an abstinence-orientated or maintenance treatment approach in the same way as those through the past hundred years. Advocates of both camps have evidence that their approach can have advantages, and the alternative approach, disadvantages. This is because each approach can be successful in achieving its own ends, but in doing so undermines the objectives of the other. There is no doubt that maintenance can reduce drug related harm (Stimson, 2007; O’Brien and McLellan, 1996) but this approach reduces the chances of eventual abstinence as it increases entrenched use and addiction (Best et al., 2008; McKeganey, 2007). Alternatively, a treatment approach can achieve abstinence and recovery but only at increased risk of relapse and overdose (Warner-Smith et al., 2001). Perhaps the best illustration of the continuing nature of these controversies is that a recent paper by O’Brien and McLellan in the Lancet in 1996, ‘Myths about the treatment of addiction’, directly reflects the views expressed in early Lancet articles of the nineteenth century (for example, Lancet, 1851: 694).

The following chapters will examine both user views and professional solutions for each type of problem in turn, and illustrate how present theory and practice reflect that of our predecessors.

- **Chapters 2 and 3**  
  Dependency and treatment (medical, psychological and disease models of treatment)

- **Chapters 4 and 5**  
  Reducing health-related harm to individual users (harm minimization)  
  Reducing heath-related harm to populations (public health interventions)

- **Chapters 6 and 7**  
  Reducing social harm to individual users (social inclusion)  
  Reducing social and ‘moral’ harm to populations (crime prevention)

It should be noted, that whilst our understanding of physical, psychological and social processes has developed in the past century, the twenty-first century may also bring a new approach to understanding
drug use. The recent study of neuroscience may contribute to understanding the short- and long-term effects of drug use partly because it enables the measurement of phenomena that were previously not measurable, such as craving, compulsion, impaired decision making and poor impulse control. At present we have little knowledge about the neurochemical processes that drugs influence and therefore little is known about the impact of drug use on these processes. Similarly, we have limited understanding of the effects of therapeutic drugs on brain chemistry and researchers have, in effect, had to guess at the neurochemical processes that underlie the outcomes of clinical trial. At present it appears as if neuroscience research will broaden clinical conceptions by focusing on a continuum of increasingly compulsive forms of drug use and craving in the context of models of normal brain functioning (Carter and Hall, 2007; Curren et al., 2001; Lyvers and Yakimoff, 2003) (see Chapter 3).

**Understanding the complexity: returning to the example of prescribed drugs**

At the start of this chapter, the complexity of drug problems and their solutions were illustrated with the example of Methadone maintenance. It is hoped that this historical overview will now enable a clearer understanding of the different contemporary reasons for prescribing Methadone and the different type of solutions it provides in terms of both care and control of drug users.

- **Prescribing substitute drugs to treat dependency and addiction (care and control)**
  Long term substitute prescribing can be seen as a treatment for a chronic relapsing illness.

  Contemporary policy and practice developed from early medical treatment at the end of the nineteenth century. This practice was again based on the early clinical premise that illicit drug use was a medical problem and prescribed drug use was the medical solution, a foundation on which many national policies and practices are based. The extensive long-term prescribing of opiates to opiate users increased significantly in the 1960s with a return to the theories of earlier medical prescribers. Drs Dole and Nyswander (1968) revived earlier notions of addiction as a metabolic disorder or physiological dependency (identified by a withdrawal syndrome), which could be effectively treated like any other chronic illness with opiate substitute medication (Methadone maintenance).
• **Prescribing substitute drugs to reduce health-related harm to individual drug users (care)**
  Harm minimization, or prescribing drugs in order to reduce the risks to individual health has been established practice for several decades. It has been shown to reduce the risk of overdose and the risks associated with injecting drugs.

• **Prescribing substitute drugs to reduce blood-borne diseases in populations (control)**
  This practice developed towards the end of the twentieth century, largely to combat the spread of HIV. It is also used to reduce the risk of hepatitis B and C.

• **Prescribing substitute drugs to reduce social harm to individual drug users (care)**
  This practice developed in order to provide a regular source of legal drugs to reduce the need for an illicit supply. It increases the likelihood of the social inclusion of users and the enhancement of social life chances, such as training, employment, leisure and housing.

• **Prescribing substitute drugs to reduce crime (control)**
  This practice developed in order to reduce the need for offenders to commit crime in order to obtain drugs. It also provided the authorities with greater control in terms of monitoring and surveillance of potential offenders.

Complex conceptual issues can lead to confusion and controversy in policy and practice if guidelines are too simplistic

It can be seen that the rationale for prescribing for treatment is different from that for public health or harm minimization objectives. The rationale for prescribing and the indicators of successful outcome become even more complicated when drug treatment is used as a crime reduction measure (DoH, 2004; Home Office, 2004). When the aims of public health and public safety are combined there is a further confusion about whether public health models of health protection or disease prevention in populations can be utilized for crime prevention (that is, whether that disease prevention and crime prevention can be understood in the same way).

It is not therefore surprising that the theoretical and ethical issues arising from prescribing practice have caused controversy amongst clinicians and consequently professional engagement in prescribing regimes can be problematic. For example Leason (2002) found that professionals were concerned about substitute prescribing maintenance...
services for those who might otherwise achieve abstinence anyway. Sondi et al. (2002) found that defence solicitors would not recommend that their clients accept drug treatment option at the point of arrest and charge. Edmunds et al. (1999) found that inter-professional partnerships working with drug users could fail because of organizational culture clashes, role conflicts and differences in values between criminal justice and treatment agencies.

Advantages and disadvantages of prescribed opiates

There are clear-cut advantages to prescribing opiates for drug users. This book will outline a wide range of research evidence demonstrating the advantages in terms of reducing suffering, saving lives, preventing the spread of disease and controlling criminal behaviour.

Opiate prescription can be useful for withdrawal when a client is already physiologically dependent on heroin or for harm minimization when there is a significant risk of health related harm (Bloor et al., 2008; Strang and Gossop, 1994; Gossop et al., 2000a; Keene, 1997b, 1997a). Long-term opiate prescription has been shown to be particularly effective within the context of a comprehensive range of other health and social care service provision with long-term, treatment withdrawal opportunities (NTA, 2002), though it is unclear how much of this success is due to the provision of health and social care services rather than opiates per se. The relationship of successful treatment and/or harm minimization to reduced crime has been more difficult to establish conclusively for the offending population as a whole (Keene, 1997a; Simpson, 2004), though there is much evidence that this is the case for a small group of heavy heroin users who are also repeat offenders (Gossop, 1996, 1998, Home Office, 2004).

In contrast, long-term opiate prescriptions might be less than useful when a client is not addicted initially or there is no significant health risk to the client or others. In these cases, it is possible that clients may become physiologically dependent on opiates, become more ‘entrenched’ in their physiological dependence, increase their addiction to larger doses, lose personal control over their drug use and/or become more dependent on services. It is unusual for clients to successfully give up Methadone scripts in a short time (McKeganey et al., 2006; Bloor et al., 2008). If the treatment conditions are not adhered to, the client may be discharged and prescription drugs terminated. This can then leave the individual client worse off as, if they have acquired a worse physiological dependency and lost previous social and market contacts, they will be faced with physiological withdrawals, unsafe illicit drugs
and unsafe illicit markets. In addition, inter-professional working and shared information might bring increased police surveillance and likelihood of future arrest.

One of the main problems in the drug use field is non-compliance with prescribed drug regimes. It is therefore important to understand both the professional rationale for prescribing and the user perspective. This is particularly relevant where patients are ambivalent about prescribed regimes of opiate drugs, because the rationale for prescribing these drugs is less clear than that for generic health prescriptions and the risks may be greater for the patient in terms of loss of control, physiological dependence and stigma. Because of the varied and complicated reasons for prescribing drugs to illicit drug users, it is important to examine reasons for poor compliance through the understandings of participants themselves, rather than assume that non-compliance is a perverse or even pathological reaction to treatment.

As McKeganey et al. (2006) point out, one of the most significant developments in the field in the past decade has been the growth of the consumer perspective. Users’ views and beliefs may be as complicated and contradictory as those of professionals and academics. Nevertheless, studies indicate that user views can be as important as those of professionals in determining the success of interventions (Keene, 1997a; McKeganey et al., 2004). It is partly for this reason that each section examines these views, before moving to the professional theories and models.

**Conclusion**

There is no doubt that fashions in theory and practice are constantly changing. As Griffith Edwards asked, ‘In the past the received wisdom was exactly the opposite of what we accept today…..How is the ebb and flow to be explained?’ (Edwards, 1989a).

Medical theories such as the Dependence Syndrome (Edwards, 1986) focus on the physiological and psychological effects of drug use, including increasing levels of physical tolerance and craving, physical withdrawal symptoms on stopping and the rapid re-instatement of physical levels of tolerance when re-starting. Psychological theories focus on the cognitive and behaviour changes that occur through the stopping period and after. However the theoretical limitations of each approach restrict our understanding. So the physical model of addiction has led us to ignore obsessive/compulsive behaviour without a clear physiological withdrawal syndrome, whereas the psychological model has led us to ignore the physical aspects of drug use. More importantly both the
medical and psychological clinical approaches may have excluded neurological or social aspects of drug use by focusing too narrowly on the physical and behavioural aspects of the ‘treatment period’ respectively. It is possible that the neurochemistry of brain changes at each stage of drug use may contribute greater understanding of these processes, particularly subjective experiences of craving and compulsion. For example, it has been shown that the decrease in dopaminergic activity caused by drug use can create disruption in limbic and prefrontal regions. This disruption can decrease drug users’ ability to control compulsive urges to use drugs (Volkow and Fowler 2000; Volkow et al. 2003), reduce self control generally (Volkow and Li, 2005) and impair decision making (Bechara et al., 1998; Yucel and Luban, 2007). In addition, these changes can make individuals more sensitive to the effects of drugs and less sensitive to the rewarding effects of natural reinforcers such as food, work and relationships. These neuroadaptations can persist for months, maybe years after abstinence, (Volkow and Li, 2004).

It is possible that the twenty-first century will again lead to greater emphasis on the importance of physiological and neurological symptoms as researchers utilize the scientific methodologies from newly developing areas of neuroscience to identify and measure chemical changes in the brains of drug users. However, it is equally possible that social science will enable greater understanding of the social processes that contribute to entrenched drug use, increasing social exclusion and relapse (Moos, 2008, 2007).

Despite the development of new theories and practice over time, the three different approaches to dependence and health and social harm have remained in place over the past two centuries. Social/moral models have been developed further, moral models are still apparent in the criminal justice approach to drug use and moral religious models are still active in the Twelve Step ‘spiritual disease’ model of addiction. Early nineteenth century public-health approaches to health-related harm have been revived in the late twentieth century, and the medical and psychological professions continue to differ over whether dependence is a physiological or psychological problem. As might be expected, the major controversies also exist today, as they did a hundred years ago. It could be argued that the history of theories of drug use has not been progressive, but circular, with present understandings being closer to those of the nineteenth century rather than the twentieth century and current policy reflecting that of the Victorians with a focus on public health and control of drug use, rather than the treatment and cure of the twentieth century (Berridge, 1998).
Differences between contemporary professional groups also reflect those of a hundred years ago, each professional group utilizing their own particular framework and theory to interpret and explain the phenomenon of drug use within the context of their professional function and remit. Professionals from psychiatry, psychology, social policy and social work provide different theoretical understandings of the process of dependence and addiction and its treatment. The controversies between social reformers, opium apologists and politicians in the nineteenth century are not dissimilar to those of public health campaigners, clinicians and politicians today (Berridge, 1998). Many contemporary arguments concerning the development of drugs policies also bear a strong resemblance to those of different professionals and interested parties at the turn of the nineteenth century. For example, arguments concerning free will and personal responsibility have been revived again in criminal justice programmes that offer ‘tough choices’ to offenders when they are arrested and charged with drug related offences (Keene et al., 2007). While this philosophical problem is complicated by the medical profession with notions of the pathology of dependency, and side-stepped by behavioural psychologists and neuroscientists with notions of a value-free science, the moral and philosophical implications regarding the nature of man and social order remain. Perhaps the continuing importance of notions of justice and retribution best illustrate the strength of the moral response to drug use. Each of these models or theories contributes to our understanding of drug use, although the variety of different ways of understanding and responding to problems can cause confusion. For this reason each of the following chapters provides a comprehensive overall framework for understanding each distinct type of drug problem and its solution.
<table>
<thead>
<tr>
<th>Index</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Key:</strong> bold = extended discussion or term highlighted in the text; f = figure; n = note; t = table.</td>
<td></td>
</tr>
<tr>
<td>abscesses 81, 97</td>
<td></td>
</tr>
<tr>
<td>abstinence violation effect (AVE) 185, 195</td>
<td></td>
</tr>
<tr>
<td>academics 15, 85, 117</td>
<td></td>
</tr>
<tr>
<td>Accident and Emergency departments 72, 73, 80, 111</td>
<td></td>
</tr>
<tr>
<td>addiction 12, 14, 17, 23, 32–3, 37, 50</td>
<td></td>
</tr>
<tr>
<td>aetiology 58</td>
<td></td>
</tr>
<tr>
<td>entrenched use 10, 11, 16, 26, 63, 85, 90–1, 94, 102, 116, 118, 128</td>
<td></td>
</tr>
<tr>
<td>literature 198, 200–1, 203–4, 206, 208, 216, 218, 224</td>
<td></td>
</tr>
<tr>
<td>meaning (drug-users’ perspectives) 22</td>
<td></td>
</tr>
<tr>
<td>moral/pathological approach 54</td>
<td></td>
</tr>
<tr>
<td>reduction 9–10</td>
<td></td>
</tr>
<tr>
<td>terminology 36, 49, 55</td>
<td></td>
</tr>
<tr>
<td>‘addictive personality’ 49, 51</td>
<td></td>
</tr>
<tr>
<td>Advisory Council on Misuse of Drugs (ACMD) 93, 193</td>
<td></td>
</tr>
<tr>
<td>aetiology 58, 63, 66</td>
<td></td>
</tr>
<tr>
<td>after-care 66–8, 152</td>
<td></td>
</tr>
<tr>
<td>drug-users’ perspectives 30</td>
<td></td>
</tr>
<tr>
<td>importance of social factors 60–1</td>
<td></td>
</tr>
<tr>
<td>long-term 37–8</td>
<td></td>
</tr>
<tr>
<td>professional procedures in event of relapse 184</td>
<td></td>
</tr>
<tr>
<td>psychological approach 180–6</td>
<td></td>
</tr>
<tr>
<td>research gaps 186, 188</td>
<td></td>
</tr>
<tr>
<td>sequential helping process 150f, 154–5, 158–9</td>
<td></td>
</tr>
<tr>
<td>social approach 186–92</td>
<td></td>
</tr>
<tr>
<td>after-care: relapse prevention and social inclusion 176–92</td>
<td></td>
</tr>
<tr>
<td>after-care assessment 179–80</td>
<td></td>
</tr>
<tr>
<td>after-care maintenance 171t, 174</td>
<td></td>
</tr>
<tr>
<td>assessment 178</td>
<td></td>
</tr>
<tr>
<td>after-care plans/programmes 153, 172, 178</td>
<td></td>
</tr>
<tr>
<td>content 179–80</td>
<td></td>
</tr>
<tr>
<td>not important consideration for agencies 66</td>
<td></td>
</tr>
<tr>
<td>age 135, 138, 205</td>
<td></td>
</tr>
<tr>
<td>agencies 87, 88</td>
<td></td>
</tr>
<tr>
<td>non-statutory 50</td>
<td></td>
</tr>
<tr>
<td>Aguirre-Molina, M. 193</td>
<td></td>
</tr>
<tr>
<td>Ajzen, I. 88, 202</td>
<td></td>
</tr>
<tr>
<td>Akram, G. 73, 202</td>
<td></td>
</tr>
<tr>
<td>Al Anon (families of alcoholics) 49, 187</td>
<td></td>
</tr>
<tr>
<td>Alateen (teenage children of alcoholics) 49</td>
<td></td>
</tr>
<tr>
<td>alcohol 7, 21, 43, 59, 67, 69, 73–5, 77, 90, 97–8, 117, 125, 147, 159, 180, 191</td>
<td></td>
</tr>
<tr>
<td>age of first use 138</td>
<td></td>
</tr>
<tr>
<td>beliefs and expectancies 40</td>
<td></td>
</tr>
<tr>
<td>safe versus unsafe use 166</td>
<td></td>
</tr>
<tr>
<td>social context of drinking (Irish men in London) [132], 223</td>
<td></td>
</tr>
<tr>
<td>social drinkers 40, 74</td>
<td></td>
</tr>
<tr>
<td>alcohol syndrome 47, 206</td>
<td></td>
</tr>
<tr>
<td>alcohol dependence/dependency 47, 61</td>
<td></td>
</tr>
<tr>
<td>alcohol problems 95, 162, 208</td>
<td></td>
</tr>
<tr>
<td>categorization (Jellinek) 48</td>
<td></td>
</tr>
<tr>
<td>Alcoholics Anonymous (AA, 1935–) 8, 24, 36, 48–50, 53–5, 193, 198, 211, 219</td>
<td></td>
</tr>
<tr>
<td>average length of attendance 68</td>
<td></td>
</tr>
<tr>
<td>Alcoholics Anonymous (Anonymous, 1976) 49, 193</td>
<td></td>
</tr>
<tr>
<td>alcoholism 37, 38, 44, 46–7, 56, 61, 133, 187, 189, 190</td>
<td></td>
</tr>
<tr>
<td>determinants of post-treatment functioning 198</td>
<td></td>
</tr>
<tr>
<td>gamma form (Jellinek) 48</td>
<td></td>
</tr>
<tr>
<td>inter-disciplinary approaches 54</td>
<td></td>
</tr>
<tr>
<td>literature 193–226</td>
<td></td>
</tr>
<tr>
<td>problem drinking 206</td>
<td></td>
</tr>
<tr>
<td>relapse 188</td>
<td></td>
</tr>
<tr>
<td>substitute drug-taking 62</td>
<td></td>
</tr>
</tbody>
</table>
Index

amphetamine/s 41, 43, 61, 97, 102, 104, 111, 204
speed 77
Amsterdam 42, 106
Anderson, D. 50, 193
anger 69, 99, 217
anger management 30, 64, 80–2, 183
Anglin, M.D. 210
anonymity 19, 110
Anonymous Fellowship 39, 49–50, 53–5, 68, 177, 188, 191
higher power 51, 52
antibiotics 81, 83, 97
antidepressant drugs 103
Antze, P. 54, 193
anxiety 62, 69, 76, 80, 82, 87, 99, 100, 112, 138, 168–9, 210, 217, 220
anxiety management 30, 64, 182
Arasteh, K. 199
arrest 14, 15, 17, 222
drug-testing (police powers) 141, 195
Arrest Referral 141, 144, 222
arteries/veins 81, 96, 97, 110, 170
Ashton, M. 11, 193
assertiveness training 183
assessment 152–3, 163–70
after-care 176
changes in category over time 167
dependency syndrome 169
dependent versus self-medicating (or both) 166–7
drug-use type 164, 165–7
execution 167–8
physical, psychological, social problems 170t, 170
problems arising from drug use 169–70
problems contributing to drug use 169
purposes 164
recreational versus risky 165–6
risks versus dependent 166
sequential helping process 150f, 151, 152–3, 154, 155, 158
specialist tools 163
assessment and care plans 149–50
assessment grid 170t, 170
asthma 97, 98
attribution theory and application 46
Australia 37, 105, 197, 198
avoidance strategies 185–6
awareness 160, 169
Azrin, N.H. 189, 207
Babor, T.F. 200
Badger, G.J. 206, 208
Bail Act (1976) 141
Bail Restriction 141
Baron, S.W. 139, 194
Baughman, O.L. 210
Bean, P. 138, 194
Beattie, M. 187, 210
Becker, H.S. 132, 194
Becker, M.H. 88, 194
Begley, E.A. 202
behavioural approach/perspective 40, 57, 58, 61, 204, 212, 218
criticisms 44
see also cognitive behavioural model
behavioural assessment 48, 181
behavioural interventions 44–5
cue exposure or extinction 45
initial assessment 44
reinforcement (positive and negative) 44
self-monitoring and self-control training 45
behavioural monitoring 47
behavioural problems 32, 69
behavioural psychologists 45, 54
behavioural psychology 55, 90
Behavioural Psychotherapy (journal) 66, 161, 214
behavioural science 38, 65
beliefs 45–6, 53, 55, 64–5, 84, 93, 117, 132–3, 162, 173, 180, 182, 185–6, 208
see also perception
Bell, J. 197
Bellack, A.S. 70, 194
Bennett, T. 138, 139, 195
Bentall, R.P. 159, 215
benzodiazepines 41, 45, 75, 98–9, 169
Bergin, A.E. 57, 100, 204
Bernal, G. 203
Berridge, V. 7, 195
beta-adrenergic receptors 41
Bickel, W.K. 207
Bigelow, G.E. 223
Billings, A.G. 183, 188, 195
‘biopsychosocial model’ 38–9, 203
Birmingham 216
black market 126
blood pressure 104
blood-borne diseases 1, 2t, 3, 13
see also hepatitis; HIV/AIDS
Bloor, M.J. 213
body language 157
Bolton, K. 107, 195
brain 6, 12, 16, 34, 41, 53, 90
Bratt, I. 55, 196
breaking denial (‘Twelve Step approach’) 51, 162, 163
bridge employment 136, 224
brief interventions 46–8, 206
aims 47
Britain see United Kingdom
British Journal of Addiction 66
‘British system’ (substitute prescribing) 10
bronchial problems 97, 98
Brott, P.E. 136, 224
Brown, B. 189, 196
Brown, D. 201
Bryant, K.J. 197
Buchholz, K.K. 220
Buhringer, G. 206
Buka, S.L. 199
Buprenorphine 42, 220
Burglund, M. 61, 215
Bybee, D. 215
Byth, K. 194
Cameron, L. 88, 210
Canada 37, 105, 194
cannabis 21, 74, 75, 98–9, 105
‘marijuana’ 137
Carballo, J.L. 220
care and control ix, 1–17
contemporary models 10–12
historical models 6–10
literature 4, 5
theory and practice (fashions) 15
underlying conflicts 148
see also health care; social control
care pathway approach 71
care plans 171–2
information required 172
intervention and post-intervention stages 172
penalties for non-compliance 172
sequential helping process 150f, 152, 158, 172
Carey, K.B. 60, 211
Carlson, B.E. 144, 200
Carmona, J.V. 215
Carrieri, M.P. 221
case management approach 71
Casey, A. 224
Casey, J. J. 11, 217
Caslyn, D.A. 70, 220
Castillo, C. 220
Castrogiovanni, P. 211
Catalano, R.F. 190, 197
‘Caution Plus’ schemes 141–2
central nervous system 90
Chalmers, J.W.T. 101, 197
Chan, D.A. 214
Charles, V. 225
chemical dependence/dependency 50, 61, 199, 222
definition 49
child care 64, 89
childhood 82, 138
children 75, 134, 143, 159
circular interactive process 83
CIS (Construction Industry Scheme) card 127
citizens’ advice bureaux 112
civil liberties 146
Clancy, C. 197
Clayton, R. 193
clients
ability to maintain change (assessment) 179
ability to maintain change (pre-assessment) 178–9
help needed from professionals 27–8
safety precautions 149
views about professionals 28–9
clinical studies 71
Cloud, W. 11, 204
co-leadership 50, 209, 226
co-morbidity 68–71
causal relationship 69
dual agency provision 72, 208
further research required 73
incidence 71–3
integration of treatment programmes 70–1
literature 199, 205, 209, 211, 212, 218, 220, 222, 225
literature review 72, 197
need-service provision gap 72–3
prevalence 202
research limitations 71–3
cocaine 21, 41, 43, 49, 61–2, 75, 89, 97, 98, 102–3, 121, 137, 143, 145, 190–1
Cochrane reviews 71, 197
coercion 2t, 3, 146
cognition 98
cognitive behavioural change 43, 153
cognitive behavioural effects 32
cognitive behavioural interventions 84, 88, 96, 99, 112, 158
contemplation stage 162, 163
continuum of dependence 38–9, 47, 74
controversies 10, 11, 16–17, 36, 38, 59
abstinence 173
care and control 148
cause and effect 167
dual diagnosis 166
minimization 108–9
partnership working 144
policy and practice 13–14
provision of information to
drug-users 110
stimulant drugs 103
terminology 39
use of Methadone 42
Cook, C. 54, 197
Copello, A. 216
coping 22, 25, 75–6, 80–1, 83–4, 100, 113, 132–3, 135, 160, 172, 177–8, 189, 192, 207
perceived inability 180
coping skills 114, 182–3
coping strategies 183, 185–6
Corkery J. 138–9
counselling 29–30, 82
advice 47, 57, 200
aims 156
generic skills 155–6
literature 198, 201, 219
non-directive, client-centred 156
sequential helping process 158–9
counsellors 99, 161
challenging and confrontation 157, 158
clarification (steps needed to achieve
goals) 157–8
feedback 157
information-collecting 157
qualities 156–7
skills 157–8
courts (of law) 141
crack cocaine 21–3, 26, 62, 75, 80, 102–3, 119–20, 127, 143, 145, 204
credit card fraud 127
Craik, R.J. 62, 197
craving 4, 12, 15, 16, 24, 31, 33–4, 36, 38, 40–1, 45, 60, 63, 67, 83, 85, 88, 128, 169, 181–3, 185, 192
drug-users’ perspectives 22–3
see also compulsion
credit card fraud 127
crime 126–8
drug use and social factors (complex
relationship) 127
effect of drug use on wider society 136
link with drug use not clear 145
literature 202, 204, 207, 212, 222
medicalization 145–6
offending rates 135
property crime/acquisitive crime 127, 137, 141, 145, 204
recidivism 14, 138, 143, 145
relationship with drug use and social exclusion 139–40, 202
relationship with drug-use 136–9, 221
serious offenders 139, 144
sub-cultures 118
Crime and Disorder Act (1998) 141, 144
Crime and Disorder Reduction Partnerships (CDRPs) 141–2

Crime problems
drug treatment versus 140–2
crime-predictors 137, 138
crime-prevention 11, 42, 148
crime-reduction x, 2t, 3, 13, 14, 101, 204
effectiveness of drug treatment services 142–4
social inclusion and 131–48
criminal justice 16–17, 144–5, 148, 208
integration with treatment services (disadvantages) 147
Criminal Justice Act (2003) 141
Criminal Justice and Court Services Act (CJCS, 2000) 141
Criminal Justice Drug Intervention Programmes 118, 140, 141, 145–6
criminal justice population 140, 207
criminal justice treatment service 128
criminal records 69, 124, 125–6, 126–7
criminological approach 133
crisis situations 171t, 178, 179
Crofts, N. 213
Crome, I.B. 197, 200
Cronkite, R.C. 188, 198, 214, 215
Crowe, S. 213
cues 45, 100, 182
Curtis, R. 202

D’Aquilia, R.T. 225
Dackis, C.A. 41, 198
Dale, A. 18, 222
Dalton, S. 216
Darke, S. 198, 225
Data Protection Act (1998) 144
Danila, B. 210
Darjee, R. 222
Davidson, R. 44, 218

Davies, J.B. 46, 198
Davis, P.E. 195
day centres 52, 56, 59, 206
De Jong, C.A.J. 196
dealers/dealing 26, 101, 106, 120, 126, 137, 139
debt 78, 80, 100, 140, 142, 172
decision 160, 161
decision-making 12
cognitive defects 90
defence solicitors 14
Demming, B. 40, 212
denial 50, 51, 162
Denzin, N.K. 53, 54, 198
Department of Health (UK) 147
dependants 168, 170
dependence/dependency
behavioural disorder 36–9
causes (drug-users’ perspectives) 25
clinical models 32
concept (consensus lacking) 36, 37
consequences 25–6
drug-users’ perspectives 23–4
general risks 25–6
meaning (drug-users’ perspectives) 22
medical definition 67
physiological addiction 36–9
physiology 39–41
sequential stages 47
simplistic notions (limitations) 32–4
solutions 7
spiritual disease 36–9
terminology 36
theories 7, 35

treatment 35–73
treatment sequence 154
types 3, 61
understanding the problem 36–9
see also drug dependence; reducing dependence

Dependency Syndrome (Edwards) 15, 200
assessment 169
dependency-reduction 9–10
depressant drugs 21, 41, 61, 75, 90, 98–9, 103, 169
see also heroin
depression 22, 25, 26, 34, 41, 43, 69–70, 75–6, 78, 82, 87, 97–9, 103, 112, 134, 138, 165–70, 178, 183, 198, 199, 211, 217
depprivation 10–11, 131, 135, 167
social 5, 133–4
Dermott, F. 70, 199
Deroo, L. 200
Des Jarlais, D.C. 113, 199, 202
detoxification 174, 191
Dexamphetamine 102, 103
diazepam 127
DiClemente, C.C. 59, 64, 65–6, 155, 159, 160–1, 162, 199, 217
Digiusto, E. 194
disease
physical 48
spiritual 48, 49, 50
see also spiritual disease model
Disease Concept of Alcoholism
(Jellinek, 1960) 48–9, 58, 207
disease model/perspective 9–10, 11, 38, 57, 58, 61, 63, 68, 70, 156, 191, 196, 202
criticism 54, 185
reducing dependence 48–55
disease of whole person
drug-users’ perspectives 24–5
terminology 36
Disulfiram 193
doctors 9, 10, 37, 76, 80–1, 84, 101, 122
see also general practitioners
Dolan, K. 198
Dole, V.P. 12, 199
dopamine 16, 41, 90
Dovaston, G. 219
drug agencies 32, 73, 80, 82, 84, 93–4, 99, 106–13, 115, 141–3, 153, 173–4
increasing caseloads 147
non-statutory 91
drug dependence/dependency ix, 3
avoidance 181
clinical treatment 5
controversies 2, 3–4, 4–5
different definitions (different methods of treatment/harm-minimization) 146–7
different solutions for different problems 1–2
effectiveness of different therapeutic solutions ix
health risks, social harm 1–17
problems and solutions (categorization) 2t, 2
problems for individual 1
problems for wider community 1
solutions (attempted) 5
theories ix, 1
treatment 35, 94, 160
wider picture (policy and practice in perspective) 4–6
see also dependence; drug-users:
perspectives on drug dependence; reducing dependence
drug networks
avoidance 128
drug outcome research 213
drug problems 208
complexity 2–4
types 1, 17
drug repertoire 169
drug seizures (statistics) 138–9
Drug Transitions Study 205
drug treatment 119–20
aims 86, 87, 109, 181
assessment and after-care plans ‘integral part’ 179
versus crime problems 140–2
different methods 146–7
expenditure (UK, 2005–6) 141
versus ‘harm-minimization’ 113–14, 114–16
HIV/hepatitis prevention and low threshold entry 93–5
methods 87
NTA definition 147
outcome measures 174–5
separated from syringe exchange 106–7
terminology 87
see also treatment
drug treatment models 55–64
effectiveness (little difference) 57
effectiveness (short-term versus long-term) 56
ideology 189
theoretical and research issues 56–63
three layers of theory 63
drug treatment programmes 113, 199
client uptake 143–4
effectiveness in crime reduction 142–4
Drug Treatment and Testing Orders (DTTO) 141
drug-crime nexus 138, 139, 194, 195, 215
causality direction 145
see also social exclusion
drug-use
antecedents and consequences 100, 166–7, 168, 169–70, 185–6
causal direction 166–7
cause and effect (confusion about) 84
cause rather than consequence of social evil 8
changing categories 168
chaotic (compulsive/risky/uncontrolled) 74–5, 78, 79, 81, 87–9, 91, 96, 99, 112, 153–4, 165–6, 167–9, 170t, 178

circular interactive process 83
continuing 21, 118, 128, 129
continuing (as social process) 121–2
controlled 58, 62–3, 65, 74–5, 154, 174, 178, 181
coping mechanism 75–6
crime and social factors (complex relationship) 127
dependent 87, 156, 166–7, 168, 170t, 185
dependent versus non-dependent 81–2, 136–7
effect of social groups 132
effect on social groups 133
effect of wider society 133–6
effect on wider society 136
effects (physical, psychological, social) ix
effects (physiological and psychological) 15
experiences of controlling, reducing, stopping 26
functions 161, 170, 179
health-related harm  ix
lack of knowledge 33
learned behaviour (professional perspective) 22
link with crime not clear 145
literature 193–226
physiological and psychological aspects 4
positive effects 33
predictor of ‘greater range/more frequent crime’ 137
problems (types) ix
problems arising 168
recreational 74, 75, 89, 102, 121, 132, 135, 165–8, 170t
relapsing 128, 129
relationship with crime 136–9, 221
relationship with crime and social exclusion 139–40, 202
safer 81, 110, 153, 172, 183, 184
salience 169
social exclusion through life-course 134–6
social habit 129–30
solutions (different types) ix
stages 20, 33
staggered 91
starting 33, 34, 118, 128–9, 131
starting (effects) 20
starting (as social process) 121
stopping 118, 128–9, 131
stopping (after-effects) 33, 34
stopping (as anti-social process) 122
supported by partners/parents 119–20
tories 16
variations 31
varying quantity ‘more dangerous’ 178
drug-use (non-dependent): risks 76–8
compulsion and lack of control 76–7
general 76
health-related 77
psychological 78
social 78
drug-use categories 165–7
drug-users viii, 1, 49
ability to change (assessment) 172
aftercare x, 176–92
ambivalence about changing 151
assessment 151–2
attitude change (conversion into behaviour change) 156
beliefs and values 173
care and control (practical guidelines) ix
categorization difficulties 165
changes in category over time 167
exclusion from non-drug-using social networks 124
experience of social care services 27
harm-minimization x
help needed from professionals 27–8
HIV-positive 113
lack of self-understanding 32–4
literature ix
loss of self-control 4
motivation, maintenance, recovery x, 149–75
needs 27
relapse-prevention techniques x
responses influenced by agency contact 32
self-medicating 166–7
social networks 117–30
social re-integration (structural barriers) 191–2
specific services needed 29–30
stabilization, support, maintenance 154
temptation 123
drug-users – continued
transition into non-drug-using networks (difficulty) 124–30, 131
treatment x
views (methodology for exploring) 18–20
views and beliefs 35
views about professionals 28–9
see also clients

IDUs 93
injecting sites (‘safer’) 110

drug-users: perspectives 15, 168
harm-minimization and public health 86
harm-minimization service 82–3
risk-taking 83
social factors (importance in drug use and crime) 117–30

drug-users: perspectives on drug dependence ix, 18–34
themes 19
theories 18

drug-users: perspectives on health risks ix, 74–85
chapter purpose 83, 84
drug-users: perspectives on social harm x, 117–30
chapter purpose 117–18

Drugs Prevention Advisory Services 222
Drummond, C. 206
dependency syndrome 169, 199

Dryden, W. 224
dual diagnosis 68–71, 166, 197, 215, 220, 226
incidence 71–3
see also co-morbidity
Duckitt, A. 201
Duffe, D.E. 144, 200
early intervention methods 47
early outcome data 47
Edelmann, R.J. 195
Edinburgh 197
education 60, 121, 131, 180, 190
basic techniques 47
method of harm-minimization 9
Edwards, G. 7, 15, 47, 57, 59, 195, 200–1, 203
‘continuum of dependence’ concept 38
dependency syndrome 169, 200
efficacy-enhancing imagery 48, 182
Egan, G. 100, 153, 156, 201
Eiser, J.R. 46, 201
emotional state/emotions 53, 61, 89
negative 180, 182
empathy 156, 157
empiricism 43, 70
employers 189
employment/work 13, 26, 30, 80, 90, 118, 120–2, 124–31, 140, 168, 180, 190, 201
dismissal/redundancy 75, 124, 127
manual labour 125
social exclusion 124, 125–6
work and social environment 186
‘Enhanced Arrest Referral Schemes’ (2004–) 142
epidemiology 47, 72, 108, 189, 218
ethics 13, 146, 148
Europe 108, 146, 205, 218
Eastern 37, 93
Northern 132
Western 37, 93–4
evaluation 174–5
Evandrou, M. 135, 201
experience 37, 63, 126, 163
Families Anonymous 49
breakdown 134
literature 201–3, 206, 209–10, 222
family systems theory 187
Index

Farner, M.E. 218
Farrell, M. 70, 71, 205
feedback 157, 164
Feigelman, B. 59, 187–8, 202
Fenley, S. 208
Fernandez-Hermida, J.R. 220
Festinger, D.S. 209
Fingarette, H. 54, 55, 202
Finney, J.W. 159, 161–2, 188, 202, 207, 214
Fischer, G. 200
Fishbein, M. 88, 202
flunitrazepam 220
Ford, P. 103
Foster, J. 139, 202
France 9
Frank, J. 54, 202
free will 17
Friedman, J.E. 215
Friedman, J.M. 215
friends 26, 67, 78, 118–19, 125, 128, 132–5, 186–8, 191, 207
Frischer, M. 73, 202
frustration 75, 183
Fuchs, D. 209
Funk, R.R. 203
GABA 90
GABAA receptors 90
Galaif, E.R. 215
Galanter, M. 59, 188, 203
Galizio, M. 38, 203
gambling 50, 77
Garcia-Rodriguez, O. 220
Garvey, K.A. 209
Gearon, J.S. 70, 194
Gebski, V.J. 197
gender 143, 187, 193
general practitioners (GPs) 13–14, 80, 96, 107, 111–13, 144, 202, 210
Genetics 50
Gilman, M. 107, 203
Ginzburg, H.M. 211
Glaser, F. 57, 203
Glaser, K. 135, 201
Glatt, M. 49, 203
Glanfield, R. 226
Godley, M. 193
Godley, S.H. 203
Goldfried, S.L. 57, 100, 204
Goldstein, A. 100, 155, 207
Gordon, J.R. 180, 181–2, 185–6, 212
Gordon, M.S. 194
Gossop, M. 40, 46, 201, 203, 204, 205, 212
Gournay, K. 226
governance of self 190, 211
Granfield, R. 11, 204
Green J. 95, 204
Griffiths, R.R. 207
Gross, M.M.
dependency syndrome 169, 200
Grounded Theory 19
group therapy 54
Grundy, E. 135, 205
guidelines (simplistic) 13–14
Hall, S.M. 53, 205
Hall, W. 70, 71, 198, 200, 205, 225
Hancock, J. 219
Handelsman, L. 207
Hanlon, T.E. 204
Harding, G. 7, 205
Hardini, R. 211
harm-minimization aims 87, 109
approaches 101–8
basic principle 88
continuing care and relapse prevention 177–8
differences from ‘drug treatment’ 113–14, 114–16
disadvantages 115–16
distinguished from ‘treatment’ 35–6, 150
literature 213, 223, 225
methods 87, 110, 146–7
moral controversies 108–9
outpatient service 173
premises 88
problems of definition/categorization 86–9
sequential helping process 150f, 154, 158
stimulant-users 102–4
strategies for reducing health-related harm 86
term ‘not used to refer to treatment of drug dependence’ 86
theoretical base lacking 88, 96
understanding the problem 89–91
see also ‘drug-users: perspectives on health risks’
harm-minimization: practical guidelines 108–14
cognitive behavioural interventions 112
harm-minimization – continued
health care provision 111
HIV and hepatitis prevention 112–13
HIV-positive users 113
information of safer injecting drug use 110
literature 199, 205
low threshold entry into drug treatment and referral to other services 112
methods 110
needles and syringes 110, 111
prescribing substitute drugs 111–12
social support and help with psychological problems 112
targeting relevant information and help 109–10
harm-minimization and public health ix, 86–116
harm-minimization services/d development 91–6
drug-users’ perspectives 82–3
harm-reduction 2t, 8–9, 11, 195
Harris, A.H. 213
Hartnoll, R. 218
Havassy, B.E. 53, 205
Hawkins, J.D. 190, 197
Haynes, P. 143, 205
Hazelden, City Centre, Minnesota (publisher) 50
Healey, A. 204
health 64, 135, 171, 197
social context, social determinants 133
see also public health
health care 111
basic 80–1, 87, 88, 105
‘conflict’ with social control 146–8
cri ses support 178
drug-users not wishing to change 151
versus social control (distinction blurred) 146
see also ‘care and control’
health care needs 96–9, 152–3
health care workers 57
health risks ix, 1, 31, 77
drug-users’ perspectives 74–85
harm-minimization service (drug-users’ perspectives) 82–3
‘individual’ versus ‘community’ 2t
possible solutions (what clients think they need) 78–9
professional help clients think they need 79–82
reasons for taking (drug-users’ perspectives) 75–8
health and safety 150f, 151–2, 172
health-related harm 3, 4, 5, 6, 16, 42
to drug-user 86
problems and solutions 2t
reduction (to individuals) 8–9, 11
reduction (in populations) 9, 11
theories and solutions 7
‘two kinds’ 86
to wider community 86
heart disease 97, 209
Heather, N. 46–8, 54, 162, 200, 205–6
help 201
with other problems 87
from withdrawal 29
see also sequential helping process
hepatitis 26, 77–8, 79, 80
and drug treatment 93–5
prevention, testing, counselling 112–13
hepatitis A 96
hepatitis B 3, 13, 26, 74, 77, 78, 96–7, 113
hepatitis C 3, 13, 26, 74, 78, 88, 96–7, 113, 170
Herman, S. 215
heroin 14, 21, 22, 26, 40, 42–3, 61–2, 80, 101–2, 103–5, 123, 127, 190–1
link with crime 136–8, 140, 143, 144–5
literature 197–8, 204–5, 209–10, 215, 217–18, 220
motivation to renounce 159, 215
smack 120
supply 137, 197, 198
heuristics 39
Higgins, S.T. 220
high-risk situations 185
planning specific strategies 182
Hill, D.E. 214
HIV/AIDS 26, 77–8, 79, 80, 101–2, 105–6
literature 193, 199, 202, 208, 212, 218, 221–5
outreach health education 108, 218
prevention, testing, counselling 112–13
HIV-prevention 92, 96, 114, 115t, 148
and drug treatment 93–5
Hodgson, R. 59, 206, 216
Hodgson, R.J. 47, 206
Holahan, C.J. 215
Holder, S. 200
Home Office 142, 143, 206
homelessness 2t, 67–9, 91, 101, 117, 122–3, 125, 127–30, 134, 194
Index

hope 51
hospitals 29
  Accident and Emergency 72, 73, 80, 111
Hough, M. 200
housing 7, 13, 64, 81, 87, 112, 120, 139–40, 169, 186
‘accommodation’ 26, 100–1, 118, 168
social exclusion 124–5
How to Combat Alcoholism and Addictions (Lefevre) 50, 210
Howes, S. 201
Hser, Y. 193
Hsieh, S. 210
Huang, D. 193
Hubbard, R.L. 211
human nature 5, 17
Hunt, G.H. 189, 207
hygiene 79, 84, 96, 101, 110
ideal types 39
ideologies 193
Ilgen, M.A. 209
illness
criminalization 145–6
  self-regulation model 88
see also disease
impulse control 12, 53
inarticulacy 21–3, 27, 32, 33, 83–4, 127
individuals x, 1, 11, 57, 92, 94
bio-psycho-social harm 2t
problems and solutions associated with
drug use 2t
social harm [suffered by themselves] 7
Inebriety or Narcomania (Kerr, 1894) 9, 209
infections 77, 81, 84, 91, 96
information 47, 80, 95, 160, 164, 171t, 172
lacking 84–5
  method of harm-minimization 9
  safer injecting drug use 110
targeting 109–11
see also knowledge gaps
information leaflets 110, 112, 113, 153
information-collection 157
information-provision 88, 92, 115, 152, 153
information-sharing 141, 144, 147–8
initial assessment 44, 45
inpatients 52, 71, 173, 209
see also residential rehabilitation
Institute for Study of Drug Dependence 103
insurance claims 59
inter-personal conflict 61, 180, 182
  predictor of relapse 188
interviews 19, 32, 74–5, 84, 118, 134, 195, 216
see also motivational interviewing
Jackson, A. 201
Jacyk, W.R. 209
Jaquith, P. 59, 187–8, 202
Jellinek, E.M. 48–9, 54, 207
Johnson, A. 218
Jordan, L.C. 215
Jose, B. 202
Kanfer, F. 100, 155, 207
Kaskutas, L.A. 50, 226
Kaufman, E. 187, 207
Kaufman, P.N. 187, 207, 222
Keene, J. 134, 139–40, 207–9
dual agency provision (co-morbidity) 72, 208
Kennedy, L.W. 139, 194
Kerkhof, A.J.F.M. 196
Kern-Jones, S. 224
Kerr, G. 9, 209
Kershaw, P.W. 61, 220
Kewalramani, A. 215
Khantzian, E.J. 69, 190, 209
Khoury, E.L. 212
Kidd, T. 204
Kidorf, M. 62, 209
Killias, M. 137, 209
Kinlock, T.W. 194, 204
Kissen, B. 193
Klain, F. 218
Kleinbaum, D.G. 197
Knapp, M. 204
knowledge base 35, 37
see also information
Kofoed, L. 70, 209
Krause, N. 135, 209
Krege, B. 46–7, 66, 161, 214
Kurtz, E. 49, 54, 209
LaMonaca, V. 209
Lancet 11
Leason, K. 13–14, 144, 210
Lefevre, R. 50, 210
legal risks 31
leisure 13, 60, 64, 118, 121, 131, 190
active interests 136 ‘recreational activities’ 189
Leo, G.I. 218
Leverthal, H. 88, 210
Levinstein, E. 9–10
Li, T.K. 90, 224
life chances 13
life course 135, 136, 175, 201
life skills 37, 68, 179
life-saving 98, 99, 153
lifestyle 31, 64, 80, 98, 100, 103, 115t, 127–8, 135–6, 139, 147, 151, 154, 164, 173, 176–7, 184, 186, 192, 198
Lindstrom, L. 54–6, 59, 187, 190, 210
listening 156–9
Little, H. 90, 210
Little Red Book (Anonymous, 1970) 49, 193
Littleton, J. 90, 210
London 205, 223
Longabaugh, R. 187, 200, 206, 210
LSD 98
Luke, D. 215
Lundwall, L. 193
lung 98
Lynskey, M. 225
MacDonald, R. 132, 134, 211
MacDougall, J. 213
MacEwan, I. 198
Mack, J.E. 190, 209, 211
MacKenzie, D.L. 198
Madden, P. 225
Maiman, L.A. 88, 194
maintenance (of change) 161
behavioural change 187
gains 61, 186
harm-minimization gains 177–8
plans 171t
post-intervention 155
pre-assessment of client’s ability 178–9
processes 60
prescription drugs
Maisto, S.A. 38, 60, 203, 211
Mankowski, E.S. 207
Marianti, R. 135, 220
Marks, S.G. 41, 198
Marlatt, G.A. 40, 44, 45, 55, 58, 155, 180–3, 185–6, 193, 202, 210, 211–12, 225
Marlowe, D.B. 209
marriage breakdown 75, 78
Marsden, J. 204, 222
Mash, E.J. 57, 212
Mason, M. 59, 222
MATCH 57, 58, 217
Maxwell, C.O. 212
May, T. 200
McDuff, D.R. 210
McFadden, M. 197
McKay, J.R. 44, 214
McKeganey, N.P. 11, 94–5, 213
McKellar, J.D. 209
McLellan, A.T. 11, 215
McNelly, E.A. 225
Measham, F.C. 117, 213
medical model 5–6, 9–10, 11, 12, 65, 66, 117–18, 155
meditation techniques 183
memory 98, 170
mental health 25, 27, 99–100, 134, 168, 208
Mental Health Alliance 146
mental health problems/mental illness 29, 69, 70, 71, 73, 89, 131, 135, 186
co-morbidity 68
mentors 131
Methadone 3
effectiveness less clear 42
harm-minimization among stimulant-users 102–4
literature 194, 197, 199, 209–11, 213, 215, 221–3, 225
prescribing ‘becoming more flexible’ 102
prescribing for harm-minimization 101–2
methodology ix, 47, 59, 134, 163
cot-morbidity research 71–2
limitations 71–2, 137–8
positivist 41
qualitative 18–20
Meyer, R.E. 200
Meyers, R.J. 190, 214
Miller, J. 197
Miller, W.R. 46–7, 64–6, 155, 159, 161–2, 200, 206, 214
Millman, R.B. 49, 214
Minnesota Experience (Anderson, 1981) 50, 193
Minnesota Method 37, 48, 54–5, 197 discharge into community 50 residential elements 50, 177
Models of Care (NTA, 2002) 147, 215
money/finance 29, 30, 78, 81, 100–1, 118, 123, 126, 127–9
monitoring 52, 64–5, 99–100, 155, 161, 164, 174, 180, 184
mood swings 33, 34, 170, 178, 220
Moos, R.H. 54, 183, 186, 188, 193, 198, 207, 209, 213, 214, 215
moral explanations/controversies 5, 10–11, 16, 54, 89, 108–9
drug-users’ perspectives 24
Quaker 7–8
moral inventory 52
Morbid Craving for Morphia (Levinstein, 1878) 9–10
Morganti, S. 221
Morgenstern, J. 44, 214
motivation (to change) 37, 164, 178–9
importance 65–6
maintenance, recovery 149–75
need 151
pre-intervention 155
process model and methods 159–63
process models (usefulness) 162–3
sequential helping process 150f, 151, 154, 155, 158
motivational change: Prochaska and DiClemente model (1986) 159, 217
action 160–1
contemplation 160, 161
maintenance of change 160, 161
pre-contemplation 160, 161
relapse 160, 161
motivational change models 64, 155, 214
limitations 162
use for drug-users 160–1, 217
motivational interviewing 65–6, 149–50, 150f, 154, 159, 161–2, 163, 200, 214
sequential stages (clearly-defined) 161–2
Murphy, R.N. 159, 215
Mwesigye, S. 197
Naloxone 98
Naltrexone 43, 44
Narcotics Anonymous (NA) 36, 37, 39, 48–52, 54–7, 68, 177
National Institute on Drug Abuse (USA) 106
National Treatment Agency for Substance Misuse (NTA/UK) 147, 163, 215
National Treatment Outcome Research Study (NTORS) 143, 203–4, 212, 222
Neaigus, A. 202
Neale, J. 213
needle-sharing (‘syringe-sharing’; ‘equipment sharing’) 26, 42, 76–8, 82, 93, 96–7, 101–2, 104–5, 110, 114, 145, 158, 172, 181, 210
needles/syringes 10, 80, 171t, 178
clean 84, 87, 88, 95–6, 91, 92, 153, 222
cleaning 111
new 110
safe disposal 110, 111
see also syringe exchange
Netherlands 105, 106
neurochemistry 16, 90
neuroscience 5–6, 8, 12, 16, 17, 53, 224
noradrenaline 41, 103
New Comprehensive Treatment Approach 198
New York City 113
New Zealand 105
nicotine 41, 53, 195, 205
nightmares 25
non-judgemental attitude 157, 159
non-statutory workers 28, 32
noradrenaline 41, 103
Nordstrom, G. 61, 215
‘Not God’: History of AA (Kurtz) 49, 209
nurses 80, 83
Nyswander, M.E. 12, 199
O’Brien, C. 11, 215
O’Shea, J. 222
old age 205, 209, 224
elderly people 89
later life 135, 209
retirement 136, 224
vulnerability 135–6
see also age
Olson, R.E. 62, 197
open coding and analysis 19
opiate addiction 7, 61, 205
consequence of social evils (C19) 7
opiate overdose 98
opiates 44, 53, 62, 73–6, 99, 103–4, 111, 145, 147, 169, 198
substitute drugs 41–2
opioid addiction 196
opioid detoxification programmes 191
opium 6
  first (UK) attempt to regulate (1868) 8
  more substantial regulation (1908–) 8–9
  morphia 10
‘opium apologists’ 7–8, 17
Oppenheimer, E. 201
Orford, J. 38, 44, 57, 200, 216
Orr, L. 201
outcome measures 174–5
outpatients 173, 206, 209
outreach 95, 106, 110, 153
  agency-orientated approach 107–8, 195, 203, 212
  extension 107
  main problem 108
  public-health approach 108, 218
overdose 8, 11, 13, 25–6, 76–7, 81, 84, 97–8, 174, 178
Oxford Group 8
Ozechowski, T.J. 224
Painter, C. 216
Palmer, R.S. 210
panic 76, 78, 113
paranoia 20–2, 24, 29–30, 33, 76, 78, 83, 104, 170
parents 89, 118, 134, 218
  supporting abstinence/treatment 120
  supporting drug-use 120
parliamentary papers 7
Parssinen, P. 9, 216
partners 67, 117–21, 129, 133, 168, 218
  lacking 119
  supporting abstinence/treatment 119–20
  supporting drug-use 120
peers 108, 117, 119, 121, 139, 140, 202, 218
  see also ‘social networks/drug-using’
perception 98, 170, 201
  decreased control in high-risk situations 180
  see also beliefs
performing (acting) 28
personal responsibility 17, 44, 51
personality 76, 215
antisocial traits 62
Petersford Community Drug Team 103–4
Peterson, T.R. 224
pharmaceutical profession 8–9
pharmacies/pharmacists 94, 105–7, 110–11, 113, 158
phenomenological perspective 18–19
physical allergy 49
physical dependency/dependence 15–16, 31, 33, 79, 116, 163, 169
  scientific research 89–90
physical exercise 100
physiological addiction 4–5, 9–10
  medical model 10
  theories 6
physiological dependency/dependence 12, 14, 15, 33, 36–9, 44, 101, 147
  reducing dependence 39–43
physiology 16
  dependence and compulsion 39–41
Pickens, R.W. 210
Poikolainen, K. 200
Poisons and Pharmacy Act (1868) 8
police 19, 78, 141–2, 144, 147–8
policy and practice 4–6
  controversy 13–14
  politics/politicians 5, 17
polydrug use 61, 104, 136, 138, 143
population studies (general) 72
Porta, M. 220
post-treatment 44, 184
  after-care and relapse prevention 178
  predictors of outcome 60
Potter, M. 61, 222
poverty 132–5, 139, 169, 192, 211
Powell, J.E. 69, 217
powerlessness 50–1, 133, 134
Powis, B. 205
practical help 88, 89
  practice 64–8
  pragmatism 89
pre-assessment
  client ability to maintain change 178–9
  pre-contemplation stage 160, 161, 162, 163
  pre-treatment assessments 179
  pre-treatment characteristics 67
  pre-treatment variables
    versus post-treatment functioning 60
Preble, E. 11, 217
prescription drugs 12–14, 81, 111–12
  complexity 2–4
  harm-minimization among stimulant-users 102–4
  non-compliance 15
opiates (advantages and disadvantages) 14–15
repeat prescriptions 10  
substitutes for illicit drug use 101–5  
see also substitute drugs  
prisons/imprisonment 15, 19, 30, 74,  
76–8, 81, 111, 113, 118–19, 123–8,  
204, 208, 222, 224  
Priu, H.D. 198  
probation service 125, 128  
probationers 198, 200  
problem-solving skills 182  
process models  
effectiveness (lack of research  
evidence) 163  
usefulness 162–3  
Prochaska, J.O. 59, 64, 65–6, 155,  
160–1, 162, 199, 217  
professionals  
ambivalence towards 149  
clients’ views 28–9  
clinicians 17, 19, 28, 39, 63, 66,  
146, 177  
controlling role 42  
generic professionals 65, 99, 100, 109,  
111, 113, 144, 149–51, 172–4, 176  
help needed by clients 27–8  
‘multi-disciplinary teams’ 87  
practicalities 149  
practitioners 36, 66, 69, 171, 172  
specialist knowledge/skills 149, 150, 151  
treatment from different sets 70  
see also counsellors; ‘relationships/  
professional-client’  
prostitution 92, 108  
psilocybin 98  
psychiatrists 37, 54, 70, 112  
psychiatry 17, 19, 70, 72, 73, 189, 199, 222  
psycho dynamic theory 209  
psychological approach/model 5–6, 11,  
15–16, 65, 66, 156  
after-care and relapse-prevention 180–6  
psychological dependence 9–10, 83, 128  
psychological factors 61, 67  
importance in relapse prevention 66–8  
psychological perspective 36  
attribution theory and application 46  
behavioural interventions 44–5  
brief interventions 46–8  
cognitive interventions 45–6  
reducing dependence 43–8  
relapse prevention 48  
psychological problems/needs 75, 81–2,  
84, 99–100, 112, 136, 139, 143, 145,  
148, 153, 165–6, 168–9, 170t, 170,  
171, 171t  
psychological risks 78  
psychological skills 176–80  
psychologists 37, 80, 82, 87, 99, 100, 112  
structured cognitive behavioural interventions 47  
psychology 17, 22, 32, 55, 60–1, 82, 88,  
127, 154, 189, 206, 216  
cognitive and behavioural changes 15–16  
see also cognitive psychology  
psychomotor ability 170  
psychopharmacology 90  
psychosocial problems 207  
psychotherapy 19, 84, 87, 202, 204  
psychoticism 73  
public health ix, 9  
harm-minimization and 86–116  
outreach work 108  
prevention initiatives 186  
see also ‘drug-users: perspectives on  
health risks’  
public safety/community safety 13  
effect of drug use on wider society 136  
Pyett, P. 70, 199  
Quakers 7–8  
qualitative methodology 18–20, 53, 62,  
163  
limitations 84–5  
quality assurance procedures 56  
quality of life 88, 189, 201  
quantitative data 163  
questionnaires 19, 118  
Quirk, A. 188, 218  
Raistrick, D. 44, 218  
Ravndal, E. 188, 218  
Raynor, P. 53–4, 208  
Reid, J. 40, 212  
reality/real world 21, 26, 39, 46, 87  
recovery 37, 51, 53, 58–9, 147, 224  
reducing dependence: approaches to  
treatment 35–73  
disease perspective 48–55  
further research required 71  
implications for practice 64–8  
literature 37–8, 41, 54, 61
reducing dependence – continued
physiological perspective 39–43
psychological perspective 43–8
theoretical issues 56–63
reducing social harm: social inclusion and crime reduction 131–48
ambivalence 148
conflicting research findings 136, 137
further research required 132–8
no simple solutions 148
research evidence 131
referral 112
reinforcement 43, 90, 100, 187
negative versus positive 170
see also CRA
relapse 161
avoidance of drug-using networks 130
different stages, different strategies 185
drug-users’ perspectives 26
likelihood 178
literature 197, 205, 210, 212, 219
peer pressure/compulsion 129
potentially-dangerous situations 179
precursors 61
professional after-care procedures 184
risk 68
social factors 186–7, 188–9
as social process 123
speed of drug-use escalation 169
types 184
relapse intervention 183–6
client action after single lapse 184–5
differentiated from ‘relapse prevention’ 183
‘essential part of after-care programme’ 185
relapse prevention 48, 176–92
behavioural theory 58
cognitive assessment and intervention procedures 183, 212
Marlatt model 155
positive expectancies of outcome 180
post-intervention 155
psychological approach 180–6
psychological and social factors 66–8
relapse prevention methods 181–3
coping skills 182–3
coping strategies 183
descriptions of past lapses 181
information about effects of substances 181–2
planning specific strategies for high-risk situations 182
rehearsals of possible future lapses 181
self-monitoring 181
teaching clients to assess risks 182
relapse rates 37, 89–90
relationships
breakdown 76
counselling 190
drug-related 118–20
interpersonal 183
marital 187
new 180, 186–92
professional-client 28, 32, 151–2, 156, 159, 163, 184
professionals and non-professionals 50
social 117, 187
relaxation 30, 64, 90, 100
relaxation training 48, 182, 183
Renton, A. 225
research 37, 43, 66
limitations (drug treatment models) 62–3
research–practice fit/gap 62, 63, 66
research evidence 35, 53
research issues 56–63
researchers viii, x, 12, 16, 36, 56
residential rehabilitation 29, 56, 173, 177
predictors of outcome 209
see also inpatients
respect 28, 32, 157
respiratory problems 98, 170
Rezza, G. 221
Rhodes, T. 108, 188, 218
Ribeaud, D. 137, 209
Richman, B.L. 215
risk-taking 50, 83, 91
Rivara, F.P. 200
Rivers, J.E. 212
Robertson, I. 46, 54, 206, 219
Robertson, M. 213
Robinson, D. 54, 219
Rodriguez, J. 208
Rogers, C., 156, 219
Rolfe, A.R. 204, 216
Rollo Committee (1924) 10
Rollnick, S. 198, 200
Roozen, H.G. 198
Rosenstock, L.M. 88, 219
Rouen, D. 198
Rounsaville, B.J. 177, 197, 219
Rowe, G. 69, 221
Royal College of Psychiatrists 146
Rubonis, A.V. 206
safe sex 112–13
safety net 149, 152, 153, 171
sequential helping process 150f, 153
saliva and urine testing 104–5
sample bias 138
San Francisco 61, 220
savings 136
Saxon, A.J. 70, 220
schizophrenia 26, 165, 194, 222
'svoices' 78
Schröder-Butterfill, E. 135, 220
Schuster, C.R. 210
SCODA (Standing Conference On Drug Abuse) 103
self-awareness 181, 182
self-control 24, 30, 40, 44, 100, 180–3, 224
drug-users' perspectives 23
loss 14–16, 31, 37, 78, 79, 83, 85, 88, 96, 99, 103, 185
training 45, 46
uncontrollability 23, 53
see also 'governance of self'
self-esteem 26, 31, 53, 83
'faith in myself' 82
self-harm 95, 135
self-help 47, 79, 219
self-help groups/networks 52, 54–7, 68, 177, 180, 188, 191, 193, 207, 214
self-medication 25, 69, 75–6, 80–1, 83–4, 99, 166–7, 168, 209
self-monitoring 45, 48, 174, 181
self-referral 112
Sellick, S. 107, 195
Semaan, S. 199
sequential helping process 152
after-care 176–92
assessment and help (vary depending upon stage) 152–3
counselling 158–9
monitoring and evaluation 174–5
motivation to change 159–63, 164
sexual behaviour 92, 93
sexual safety 70, 218
Sheehan, M. 201
Shelter 125
short-termism 56, 60, 65
significant others 157, 187, 209, 214
Simpson, D.D. 11, 136–7, 221
Sinclair, J. 95, 204
Sisson, R.W. 193
skills training 68, 139
skin infections 170
sleeping tablets 29
Slegg, G. 216
Sloan, K.L. 69, 221
Smith, D.E. 210
Smith, I. 219
Smith, J.E. 190, 214
Smith, M. 219
Smithson, M. 197
smoking 65, 160–1, 166, 186, 195, 199, 201
Sobell, L.C. 218
Sobell, M.B. 218
social approach to after-care 186–92
future of community programmes 191–2
importance of after-care 189–90, 207
research gaps 186
social capital 132, 134
social care 14
drug users' perspectives 27–8
social class 7, 132, 134
social context 43, 167, 168
social control 10
conflict with health care 146–8
versus health care (distinction blurred) 146
see also 'care and control'
social environment (safer) 186–92
social epidemiology 133–4
social exclusion 124–7, 133–6
drug use and 134–6
greater for offenders 126–7
housing and employment 124–6
relationship with drug use and crime 127, 139–40, 202
social factors 10–11, 37, 53, 63, 169, 215
importance 59–60
importance in after-care 60–1
importance in relapse 188–9
importance in relapse-prevention 66–8
importance in treatment 187–8
influence on relapse 186–7
social groups
danger (drug-user perspective) 30
effect of drug use 133
effect on drug use 132
social harm ix, 1, 2t, 3, 4, 16
to community 7–8
drug-users' perspectives x, 117–30
to individuals 13
problems and solutions 2t
reduction 11
social harm – continued
  theories and solutions 7
  types 117
  see also reducing social harm
social inclusion x, 2t, 11, 13, 176–92
  and crime reduction 131–48
social learning theory 43, 47, 57
social model 7, 8, 16
social needs 100–1, 171, 171t
social networks 176–80
  conventional 26, 129, 188
  criminal (avoidance) 128
  drug-using 108, 118, 121–2, 123,
  128–30, 131, 178, 192
  drug-using versus non-drug-using 124,
  130
  non-drug-using (difficulties of finding) 187
  non-drug-using (drug-user isolation
  from) 121–2, 124
  transition between 192
  values 132
social policy 17, 92
social pressure 61, 180, 182
social problems 6, 84, 115, 139, 145, 148,
  169–70, 170, 170t
social risks 78
social skills 37, 60, 64, 66, 68, 133, 150f,
  183, 190
  training 140, 182
social support 49, 54, 60, 81–2, 112, 114,
  115t, 118, 139, 179, 195
social support networks x, 154, 164, 171t,
  172, 178, 180
  non-drug-using 131
  ‘support networks’ 64, 150f
social treatment programmes 59–60
social work 17, 208
  emphasis on psychodynamic change 89
social workers 57, 87, 99
society
  effect of drug use 136
  effect on drug-users 133–6
  see also community
Society for Suppression of Opium Trade
  (SSOT, 1874–) 7–8
socioeconomic status 67, 209
sociological-phenomenological
  perspective 46
sociology 132
solvent use 98
Sorensen, J.L. 203
Sovereign, R.G. 46–7, 66, 161, 214
Spain 191, 220
Spear, S.F. 59, 222
specialists 159
Spencer, L. 18, 222
spiritual disease model 5, 16, 36–9, 54
  disease of human spirit 50
spouses 168
Stanton, J. 7, 195
starting period (induction phase) 33, 34
  see also drug-use
Stastny, D. 61, 222
Steinglass, P. 187, 222
Stenner, K. 208
Sterling, R.C. 206
Stewart, D. 203, 204, 212, 222
stigma 15, 124, 131, 165, 187, 192
Stillwell, G. 224
Stimson, G.V. 11, 91–2, 108, 218, 222–3,
  224, 225
stimulants 20, 21, 62, 74, 75
  see also cocaine; crack
Stitzer, M.L. 62, 209, 223
Stockwell, T. 37, 44, 223
stopping period 33, 34
  see also drug-use
Strang, J. 42, 205, 223
stress 68, 100, 133, 169, 177, 180, 186,
  205, 214
stress at work 187, 188
stress management 48, 64, 182, 183
sub-cultures 118, 132, 133
subjectivity 36, 40, 46, 88, 163, 169, 201
substance abuse 71, 72, 166, 194, 203,
  207–10, 221
  co-morbidity 68
  NTA definition 147
  rationales for intervention 147
substitute drugs/substitute
  prescriptions 12–13, 41–3, 101–4
  dependency 102
  reduction of blood-borne diseases 13
  reduction of crime 13
  reduction of health-related harm to
  individual drug-users 13
  reduction of social harm to individual
  drug-users 13
  see also maintenance prescription
Subutex 42
suicide 8, 70, 83, 211
Summerhill, D. 42, 223
supply control 5
Sutton, S.R. 46, 201
Sweden 105
syringe distribution schemes 105
syringe exchange 93, 94, 105–6, 109–11, 113, 115t, 153, 158
separated from ‘drug treatment’ 106–7
Tabisz, E. 209
Tato, J. 220
taxation 125
Taylor, C. 201
Taylor, D. 69, 217
Temazepam 81
temperance/sobriety 8, 53
Terdal, L.G. 57, 212
Teruya, C. 193
therapeutic change 156, 158
therapeutic input 115t
Thomson, L.D. 222
thought control (loss) 33
thrombophlebitis 97
thrombosis 77, 96, 97
Tilk, M. 132, 223
time 31, 33, 41, 45, 56, 59, 60, 67, 70, 121, 155, 163, 167, 168, 174, 176, 178, 182, 184, 189, 191, 200
Tipp, J.E. 220
Tonigan, J.S. 214
Topp, L. 198
Torrens, M. 220
training 13, 80, 126, 180
occupational 186
professional 57, 71, 89, 110, 173
treatment
ambulatory 220
concept 186
contradictory approaches (coexistence) 55
core components 64
core components (further research) 58
cost-effectiveness (alcohol abusers) 210
distinguished from ‘harm-minimization’ 35–6, 150
during-treatment variables (versus post-treatment functioning) 60, 61
efficacy 6
importance of social factors 187–8
integration with criminal justice (disadvantages) 147
literature 193–4, 197–8, 200, 203, 206, 208, 210–11, 213–14, 217–18, 220, 224
maintenance of gains 139
matching hypothesis 57, 203, 217
medical, psychological, and disease models 11
methods 64
objectives 64
problems of definition 35–9
psychodynamic aspects 42
reducing dependence 35–73
refused 151, 152
responsiveness 162
sequential helping process 150f, 154, 158
short-termism 56
trans-theoretical therapy 65–6, 217
see also drug treatment
treatment change care plan 171t
treatment change processes 60
treatment compliance 15, 105, 147, 172
treatment costs 141, 142, 144–5, 204
treatment gains
loss of 180
maintenance 186
retention 191
treatment models 55–64
limitations of research 62–3
treatment outcomes 47, 59, 67, 143, 158–9
literature 203, 217, 218, 223
treatment process
absence of coherent theory 63, 66
core components 58
further research 59
importance 58–9, 65–6
trigger offences 141
Trinder, H. 99, 208
trust 28, 51, 77, 144, 159
Turnbull, P.J. 200
Turner, C.W. 224
‘Twelfth Stepping’ (step 12) 52–3
Twelve Step model 50–5
drop-out rate 53
effectiveness (limited evidence) 54
inpatient treatment (Steps 1–5) 50–2
literature 214, 226
relapse prevention (Steps 6–12) 52–3
‘scientifically-credible opponents’ 53
‘spiritual disease’ model of addiction 16
Ulrich, L.B. 136, 224
unemployment 2t, 67–8, 69, 117, 126, 134, 167, 169
life sentence 125, 127
United Kingdom  42, 72, 106, 114, 132, 146, 148, 191

Britain  6, 8, 10, 37, 39, 48, 54, 68, 89, 91–2, 93–4, 177

England  141
Scotland  213
‘Wales’  208, 222
Alcohol Treatment Trial  216
drug strategy  140–1, 206
drug treatment versus crime problems (policy and practice)  140–2

United States  8, 37, 42, 48, 55, 57–8, 68, 93, 94, 106, 108, 146, 166, 191, 218
unmanageability concept  51
Urquia, N.  200

Vaglum, P.  188, 218
Valliant, G.E.  56, 61, 224
van Rossum, L.G.M.  198
violence  69, 76, 84, 100, 134, 135, 137, 143, 222
vocational activities  189
Volkow, N.D.  90, 224
voluntary work  131, 180

Wasserman, D.A.  53, 205
Watson, L.  201
Webb, H.  216
Webster, R.  224
welfare  64, 80, 140
Wells, E.A.  197
Wermuth, L.  203
West, R.  200
White, H.R.  212
Wilkinson, C.  138, 194
will power  24, 31
Williams, T.  222
Wilton, S.  216
Winterburn, D.  138, 194
Winters, K.  200
Wirral Drugs Service  108
withdrawal  14, 29, 30, 32, 36, 38, 67, 69, 75, 98, 128, 147, 168–70, 178, 181–2, 217
withdrawal effects  45, 99, 103
withdrawal programmes  87
withdrawal symptoms  15, 25–6, 33–4, 39–42, 89–90, 169
importance  41
withdrawal syndrome  12, 37
Witkiewitz, T.  44, 225
Wodak, A.  213
women  70, 106, 143, 185, 188, 218
Wong, C.J.  206
Wood, E.  199
working with users: motivation, maintenance, recovery  149–75
assessment  163–70
clarification of aims and objectives  149, 151, 156, 175
further research required  159
longitudinal studies  175
monitoring and evaluation  174–5
new beginnings and no end  151–5
research evidence lacking  163, 166
research literature  155, 159
sequential helping process  150f
status of theory ‘dependent on usefulness’  173
untested theories  173
‘working-class opium eating’  7
World Health Organization (WHO)  38–9
young people  106, 108, 112, 133, 135, 139, 201
adolescents  69, 70, 194, 197, 199, 203, 206, 224
juveniles  209
teenage children  49
Youth Offender Teams  140
Zeena, T.H.  199
Zemore, S.  50, 226
Zhang, Y.  212
Zolesi, O.  211