## Contents

*List of Illustrative Material* ix
*Introduction* xiii
*Acknowledgements* xvi
*List of Abbreviations* xvii

### PART I  Context and Theory

#### 1  Defining and Experiencing Substances 3
   - The language maze 3
   - Central concepts 4
   - Experiencing drugs 8
   - Substances: the central nervous system and the liver 8
   - Commonly encountered substances 9
   - The individual and the environment 14
   - Concluding comments 16

#### 2  What Is a Substance Problem? 17
   - A superfluous question? 17
   - Substances: different drugs, different risks 19
   - The individual: some people run greater risks than others 21
   - The environment: risks to users 24
   - Social consequences and the harm to others 24
   - Models for making sense of risks and harms 25
   - Concluding comments 27

#### 3  Why Do People Develop Substance Problems? 29
   - Individual pathology or social forces? 29
   - Sociological theories: it’s cultural forces that count 31
   - The disease model and genetic theories: some people are different 35
   - Learning theories: much the same for everyone 39
   - Psychoanalytical theories: substance problems as symptoms 43
   - Gateway theory 45
   - Substance problems as choice 46
   - Integrated approaches; the bio-psycho-social model 47
   - Concluding comments 49
Cultural Trends; Social Control

Cultural influences on use 50
Social control: various options 52
Judging effectiveness 56
Substances in the UK since 1960: a shifting scene 57
Concluding comments 66

Why and How Do People Change?

Behaviour change 67
Unassisted recovery 68
Triggers and the maintenance of change 71
The cycle of change 75
Concluding comments 77

PART II Interventions in Practice

Effective Interventions, Competent Practitioners, Successful Services

What makes the difference? 81
How do we measure success? 82
Controversies, controversies 83
Interventions 86
Practitioner skills in context 89
Successful services 95
Concluding comments 99

Assessment and Care Planning

Assessment: context and principles 100
The processes of assessment 101
Assessment: covering the ground 104
Care planning 114
Concluding comments 119

Motivational Interviewing

Motivation: the key to the door of change 121
The essence of motivational interviewing 123
The practice of motivational interviewing 125
Concluding comments 130

Harm Reduction; Less Intensive Treatment; Brief Interventions

Different but connected 132
Harm reduction 133
Less intensive treatment 139
Brief interventions 140
Concluding comments 142
10 Pharmacological Treatments
Pharmacotherapy: a central intervention for some
The purposes of pharmacotherapy
Opiates
Alcohol
Psychostimulants
Benzodiazepines
Nicotine
Vaccines
Concluding comments

11 Interventions: Specific Approaches
The foundations of effective interventions
Cognitive behavioural therapy (CBT)
Mutual aid groups and self-help resources
Controlled drinking
Working with stimulant users
New psychoactive substances and club drugs
Concluding comments

12 Relapse Prevention, Endings and Follow-up Care
Perspectives on relapse
Relapse prevention using CBT methods
Endings and follow-up care
Concluding comments

PART III Specific Populations

13 Psychological Distress and Substance Problems
Dual diagnosis: an unhelpful term?
The links between psychological distress and substance problems
Co-occurring problems, multiple difficulties
Prevalence
How services are provided
Assessment, care planning and interventions
Concluding comments

14 Children Affected by Parental Problems
Children affected
Children affected: the role of substance problems practitioners
Concluding comments

15 Significant Others: Adults
Significant adults
Drugs and alcohol: the impact on significant adults
Significant adults: assessment 219
Significant adults: care planning and interventions 220
Significant adults: supporting the substance user 223
Concluding comments 224

16 Young People: Substance Use and Substance Problems 226
Young people’s substance use 226
The structuring of services 230
Engagement, assessment and care planning 232
Interventions 235
Concluding comments 239

17 Offenders and Other Involuntary Service Users 240
Voluntary and involuntary 240
Engagement 241
Employee policies 242
Substance problems and the criminal justice system 244
Intervention with involuntary service users 248
Concluding comments 250

Appendix: Validated Questionnaires 252
References 257
Index 275
PART I

Context and Theory
Defining and Experiencing Substances

KEY THEMES

- It is important to use language precisely as it influences both how we view people experiencing difficulties with substances and society’s efforts to devise strategies to reduce the harms.
- Dependency and addiction are central to our understanding of substance problems but are difficult to define. Many concepts surrounding substance use remain contentious.
- Psychoactive substances can be categorised by their different effects on the central nervous system.
- Phenomena such as tolerance, withdrawals and overdose can be explained to a great degree, but not entirely, from a physiological perspective.
- The chemical properties of a drug alone do not account for how a person experiences it. This is predicated on a complex interaction between the individual, the environment and the substance itself.

The language maze

Addiction and dependence are difficult to define but, as concepts, they tend to mould our understanding of what problematic use of substances is. In the public mind, substance problems are often synonymous with ‘addiction’, but this is an example of language shaping – and limiting – our perception because people can experience problems with substances, irrespective of whether they are addicted or not. The term ‘alcoholic’ is used to describe the dependent drinker, a person who appears unable to stop when he starts and who uses most of the time. This stereotype has come to define what problem drinking is, thus minimising the risks inherent in bingeing or regular heavy use. Two examples illustrate the problem. I remember Mitch Winehouse, the father of the singer, Amy, saying that, initially, he was not overly worried by his daughter’s heavy alcohol use. He did not think she was an ‘alcoholic’ as she did not drink all the time – a good example of how a word can influence understanding. At that time, for Mitch, a drink problem constituted persistent, dependent use and no other pattern. In a similar vein, Ward, Henderson and Pearson (2003, p. 30) describe how a group of care leavers dismissed concerns about
their drug use by measuring this against the idea of ‘addiction’: ‘Addiction was the point of reference that many of these young people used in defending the extent to which they used drugs, justifying their continuing use on the grounds that they were “not addicted”.’

The problem is not confined to how people make sense of their own or other people’s use on an individual basis. The drinks industry has a vested interest in presenting Britain’s alcohol problem as residing with a small minority of irresponsible or ‘problematic’ drinkers rather than being a wider public health issue involving excessive consumption by a significant proportion of the population. Such a view can then influence political decisions regarding what measures should be put in place to reduce the harms.

Words used to define specific concepts within the substance problems field have spilled over into common parlance to refer to unrelated ideas. Thus we have the media describing politicians as ‘being in denial’ over the outcome of their policies. Within the disease model, ‘being in denial’ is a characteristic which ‘alcoholics’ are deemed to possess – a controversial concept; however, we think we know what it means. Problems with language can become absurd. Detoxification refers to a specific process of ridding the body of poisonous substances and is used primarily to refer to alcohol and drugs. What are we to make of a company advertising ‘corporate detox solutions’ and a book entitled *Detox your Finances: The Ultimate Book of Money Matters for Women* (Trueman, 2009)? It is little wonder that concepts, which are both difficult to define in the first place and contentious within the substance problems field, become further muddied through imprecise use.

Words can reinforce stigma which, in turn, may militate against a person’s recovery. ‘Junkie’ conjures up the idea of a hopelessly dependent individual living a squalid existence in a shadowy subculture with nothing to contribute to society. The phrase ‘person with a drug problem’ invokes a very different image. A junkie is not one of us, a person with a drug problem is.

If we are to make sense of substance use and substance problems, we need to use language with care.

**Central concepts**

**Drugs, addiction and dependence**

**Drugs** are consumed in most societies. Vast, complex industries, both lawful and illicit, surround their production and marketing. They are used for medical and recreation purposes. They can be defined by their effects on the central nervous system or by their legal status. But what are they? Gossop argues that cultural significance and methods of use are as important as chemical properties when struggling to define ‘a drug’, a notion he considers to be a ‘social artefact’ (Gossop, 2007, p. 2). Most people would agree that heroin is a drug, but when it comes to solvents, the response might be ‘in particular circumstances only’. In respect of the non-medical use of substances, we are primarily referring to those which are psychoactive, in Edwards’ words ‘mind-acting’- they alter mood and cognitive functioning (Edwards, 2005, p. xvii).
Even this is unsatisfactory; steroids may affect mood but that is not why people take them.

If the concept of a drug proves hard to pin down, addiction and dependence present even greater difficulties. Addiction is commonly used as a pejorative word to describe an unhealthy preoccupation. Dependence is often used to mean the same thing. However, there are two separate but overlapping phenomena at work here:

- **Physical dependence.** Persistent, heavy consumption of some, but not all, substances leads to adaptations in the functioning of the central nervous system. When this occurs, more of the substance is needed to achieve the same effect: this is tolerance. If the person then stops using abruptly, the central nervous system reacts until it has readjusted to the absence of the drug: this is withdrawals. Raistrick, Heather and Godfrey (2006, p. 128) argue that ‘physical addiction’ can be a confusing term for these processes of neuroadaptation but it is hard to find another phrase that makes the concept clearer. What is important is that physical dependence is a physiological process which anyone who takes certain drugs will experience if he consumes regularly and heavily. Psychological factors need not come into the equation. For example, a person prescribed morphine to control pain over a period will become physically dependent and withdrawals will occur if he suddenly stops; however, he may feel no desire to use beyond wanting to ward off the discomfort of withdrawal. With regard to tolerance, it is not the case that heavy users simply consume ever-increasing quantities. After a period of escalating consumption, a person tends to find a dose level which he then maintains (Gossop, 2007; West, 2006). For example, a regular smoker will stick to approximately the same number of cigarettes a day or a dependent drinker the same amount of alcohol. Both psychological and physiological factors may be at play here. With regard to physiological factors, a ceiling on the capacity of the individual’s nervous system and liver, and balancing changes in the neurotransmitters, lead to a particular baseline of use.

- **Psychological dependence.** Here the person experiences a feeling of needing to take the substance irrespective of whether physical dependence is present. Many people exhibit mild psychological dependence, an example being wanting a few drinks to cope with social occasions. At the other extreme, psychological dependence can be experienced as a preoccupation with substance taking, involving overpowering feelings of being unable to cope without using and overwhelming cravings.

The jazz great Charlie Parker (undated), who had serious difficulties with heroin, neatly encapsulated these different facets of dependence: ‘They can get it out of your blood but they can’t get it out of your mind.’

It is the combination of psychological and physical dependence which we tend to call ‘addiction’. Problems with defining addiction led the World Health Organization (WHO, 2013a) to replace it with the concept of the dependence syndrome:
A cluster of physiological, behavioural, and cognitive phenomena in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviours that once had greater value. A central descriptive characteristic of the dependence syndrome is the desire (often strong, sometimes overpowering) to take psychoactive drugs (which may or may not have been medically prescribed), alcohol, or tobacco. There may be evidence that return to substance use after a period of abstinence leads to a more rapid reappearance of other features of the syndrome than occurs with nondependent individuals.

The WHO (2013a) then suggests that a diagnosis of the syndrome can be made if a person displays three or more of the following characteristics at the same point in the previous 12 months: a desire to use; problems of control; withdrawals; tolerance; disregard for alternative activities; continuing to use despite problems.

This certainly captures a pattern of substance use distinguished by fixation with drug taking and an apparent inability to exercise restraint. However, it does not solve all the difficulties of definition. West (2006, p. 174) notes that addiction is a ‘social construct’ with ‘fuzzy boundaries’ and so, too, is the WHO concept of a dependence syndrome. Three characteristics and a cut-off point of one year are arbitrary. An individual diagnosis is involved, a medicalized approach, which divorces a person’s behaviour from its social context which, to some degree, determines whether it can be considered ‘abnormal’. The definition does, however, avoid suggesting that dependence is always problematic. This is important. While in most cases it will be, what is a problem depends on whose perspective is taken. A person who smokes cannabis daily to relieve the pain and spasms of multiple sclerosis might meet the WHO diagnosis of dependence but he might view use as being highly beneficial rather than a problem.

Although no solution is without difficulties, for the sake of simplicity we will use the term ‘dependence’ in preference to ‘addiction’ in this book. It will be used in line with the broader WHO definition above rather than its more rigid diagnostic interpretation.

However dependence is defined, it does not include other patterns of use such as bingeing or heavy consumption, short of dependence, which can bring a range of problems. This is the difficulty discussed at the start of this chapter. Another category introduced by the WHO (2013a) can help us here: that of ‘harmful use’: ‘A pattern of psychoactive substance use that is causing damage to health.’

The World Health Organization includes both physical and psychological problems in this definition, along with possible detrimental social repercussions. While not a formal diagnostic category, the WHO (2013b) also notes that use can be ‘hazardous’, a pattern of substance taking with a heightened risk of physical, mental or social harms occurring. By introducing the concepts of harmful use and hazardous use, the WHO is emphasising that problematic substance taking is not limited to issues of dependency.
Defining a substance problem

Before reading Chapter 2, complete the following sentence:

A substance problem is ...............................................................  

Some other definitions

Many concepts in the substance problems field are ambiguous or contentious: examples include controlled drinking, recovery and harm minimisation. These, and the controversies surrounding them, are explored in future chapters. The following is an attempt to pin down some other common concepts.

**Abstinence** means refraining from use. It is usually applied to desisting from one drug only. A drinker who is abstinent may still smoke.

An overwhelming desire to use is described as **craving**. Cravings can have a physiological dimension, as experienced in withdrawal, and psychological aspects. Some people describe overwhelming desires to use, even after lengthy periods of abstinence. Whilst cravings can occur for no apparent reason, places, people or objects associated with past use can be triggers.

The disease model suggests that those who are addicted display distinct characteristics: one of these is **denial** (see Chapter 3). The dependent person is considered to be oblivious to what is patently obvious to those around him, namely that his use is out of control and is the source of other problems in his life. Denial is a controversial concept. Behavioural psychologists argue that what is interpreted as denial is often a defensive response to unwanted criticism or hostile questioning, rather than a characteristic of people with substance problems (Miller and Rollnick, 2013).

**Detoxification** is ridding the body of a psychoactive substance.

A bewildering array of new substances has become available in recent years. Many of these mimic the chemical composition of traditional drugs. Often called ‘legal highs’, **new psychoactive substances** is a better description since a number of them are not legal. Some, however, are not new.

**Polydrug use** describes the habit of either using two or more substances together or separately but on a regular basis.

**Recreational use** describes taking a substance in a non-dependent, ‘as and when’ basis; the user feels in control. Recreational use is not necessarily harm free.

**Relapse** is a return to use following a period of abstinence. It can also denote the reinstatement of problematic use after a person has controlled his substance taking in a harm-free way.

**Volatile substances** is a generic term for hydrocarbons whose vapour can be inhaled. They are contained in numerous everyday products.
Experiencing drugs

How a drug is experienced is unique to the individual. Alcohol depresses the central nervous system. However, a person, having drunk a couple of glasses of wine, will feel and behave very differently relaxing with friends compared to sitting next to a feared superior at a formal dinner. One person may have a tendency towards exuberance after drinking, whereas another may become argumentative. These differences reflect a complex mix of biochemistry, physiology, learned behaviour, expectation and the influence of past and present environments. Zinberg (1984) categorises these as ‘drug, set and setting’. Incidentally, modern thinking about ‘treatment’ suggests that a person needs to address these three domains (the substance, the individual’s responses and the barriers and reinforcers in the environment) if recovery is to become a reality. Before we explore this further, it is important to consider aspects of the chemistry of psychoactive substances.

BOX 1.1 MISUSE: A LOADED TERM

Misuse [or abuse] is the term frequently applied to any use of substances which are illegal or which are consumed in a risky manner. In government documents, use of drugs subject to the Misuse of Drugs Act 1971, unless taken as prescribed, is referred to as ‘misuse’. However, drinking alcohol is not considered to be misuse unless it is consumed in potentially harmful ways. The word ‘misuse’ suggests that there is a consensus regarding what is acceptable and unacceptable use of substances. As this is far from the case, the words misuse and abuse are not used in this book.

Substances: the central nervous system and the liver

Substances affect the central nervous system in various ways. Shapiro (2010) classifies drugs as:

- depressants
- drugs which reduce pain
- stimulants
- drugs which alter perception (hallucinogens).

Depressants and drugs which reduce pain are often grouped together and volatile substances are sometimes considered as a separate category. To complicate matters, a number of substances have effects which do not allow for easy classification: cannabis is a depressant which alters perception; ketamine presents a particularly complex range of effects.

In whatever way substances are ingested, they all enter the brain via the blood stream and are eventually eliminated from the body. In the brain, drugs work by interfering with the balance of the natural processes of the
central nervous system. The cells in the central nervous system (neurons) communicate with each other via an electrochemical process which sees chemical messengers (neurotransmitters) fired from one cell across a small gap (the synapse) to a receiving cell (receptors). In this highly complex system, different sets of neurons have different functions geared to protecting the survival of the organism and its species. Neurotransmitters make the receiving cell more or less likely to activate, thus stimulating or inhibiting certain processes. In some circumstances, a proportion of neurotransmitters will be reabsorbed back into the neuron which fired them (a process called reuptake). Some drugs mimic the effects of neurotransmitters, thus enhancing their effects as they latch on to available receptors for that neurotransmitter. Other drugs prevent reuptake, thus increasing the amount of that neurotransmitter available.

Alcohol and cocaine provide contrasting examples of how aspects of the system work. Gamma-aminobutyric acid (GABA) is a neurotransmitter which dampens activity within the system. One characteristic of alcohol, among many, is that it binds onto the GABA receptor, hence its depressant effect. Cocaine acts in a different way. Dopamine is responsible for the pleasurable feelings linked to eating and sex, among other things, and cocaine increases the amount crossing the synapse by preventing its reuptake in the neuron which fired it, along with the reuptake of other neurotransmitters. Because of the complex and diverse actions of any particular drug in the central nervous system, the desired effects often come with unwanted side effects.

Substances can be removed from the body via breath and sweat but the key organ is the liver, in which they are broken down by enzymes for the purposes of excretion.

Commonly encountered substances

Depressants

Alcohol and the so-called minor tranquillisers, along with gammahydroxybutyrate (GHB and GBL) and barbiturates depress the central nervous system. Their use tends to facilitate relaxation, with increased dosage leading to reduced motor control, resulting in staggering and slurred speech, and diminished mental performance.

Alcohol initially depresses the centres in the brain controlling inhibition, which explains why euphoria and feelings of excitement can accompany ingestion of what is a depressant drug. Heavy drinkers often seek treatment for the low mood generated by their substance use. Alcohol has no current medical applications. Used in significant quantities over a period of time, it is associated with a wide range of health problems including various types of cancer, heart disease, cirrhosis of the liver and alcoholic dementia.

The prescribing of barbiturates, once common for anxiety and insomnia, is now rare because of the risks they present. In particular, the line between therapeutic dose and overdose is quite fine. They are not readily available on the black market.
Prescribing of benzodiazepines, the most common of the minor tranquillisers, reduced the use of barbiturates in the late 1960s. Diazepam (also known by the defunct brand name Valium), chlordiazepoxide (Librium), nitrazepam and temazepam are examples of these. Initially they were seen as wonder drugs, providing a problem-free route to controlling anxiety and insomnia. The fact that overdose only occurs at very high levels was a particular attraction. It was only after their therapeutic use had become established that it became evident that physical dependence and associated withdrawals are an issue, along with reduced effectiveness after fairly short periods of use. In addition, when taken with other depressants, as they often are, risk of overdose is increased. Benzodiazepines are usually taken orally but some can be injected or ground down and snorted.

Gammahydroxybutyrate (GHB) and its sister, gammabutyrolactone (GBL), which is metabolised into GHB when ingested, are normally taken orally in liquid, capsule or powdered form. GHB acts as a sedative and anaesthetic. Initial euphoria and reduced inhibition can lead, with increased dose, to nausea, convulsions, breathing problems and coma. The intoxicating effects of GHB can be quite long lasting. Physical dependence can occur.

The term volatile substances covers a very wide range of hydrocarbons which give off inhalable vapour. Many everyday products, such as adhesives, cleaning fluids, petrol and butane (lighter fuel and the propellant often used in aerosols), contain such substances and are cheap and readily available. The effects, which are similar to being intoxicated on alcohol, are short lived. Reduced inhibition, elation and dizziness may be followed by a hangover. Users can experience hallucinatory effects. The small number of deaths associated with volatile substances have occurred through accidents following use, suffocation when inhaling from plastic bags or from the effects on the heart. Long-term use can lead to health problems, with dependence being psychological rather than physical.

**Pain-reducing drugs**

Depressants tend to have an anaesthetic effect, as anyone who has injured himself after drinking will know. However, drugs which are used routinely in Western medicine to control pain, generically classed as analgesics, are usually categorised as a separate group. Common analgesics, such as aspirin and paracetamol, do not lead to physical dependence; however, their ability to reduce discomfort may lead to compulsive use. In this book, the term opiates is used as the collective term for drugs which act within the central nervous system in a similar way to morphine. Strictly speaking, opiates are derived from the poppy and opioids are their synthetically produced cousins. Contrary to popular myth, opiates are relatively safe drugs. Pharmaceutical heroin taken daily in controlled doses and ingested with care will lead to physical dependence but not to the damage to the organs wreaked by excessive alcohol use. Many of the harms linked to heroin come from how it is used and from illicit supplies. Morphine, codeine and heroin are examples of opiates, whereas methadone and pethidine are
Index

Note: page references in bold indicate definition or extended examination.

5-step method, 221
12 steps, 37, 87, 11, 164–6, 168, 182
   see also Alcoholics Anonymous; Cocaine Anonymous

AA
   see Alcoholics Anonymous

ABC model Ellis), 157
abstinence, 7, 36, 39, 83, 84, 164–7
   goal setting, 116–17, 169–70, 175, 203, 234
   as smoking policy, 57, 138
abstinence violation effect, 181–2, 186
abuse
domestic, 94, 97, 112–13, 117, 208, 224
   physical and sexual, 44–5, 208
acamprosate, 150
acetaldehyde, 3–8, 150
   disulfiram causes build-up of, 150
   oriental flush, 38
action plan
   see care planning
acupuncture, 175
addict
   identity as, 34–5, 73–4, 122
addiction, 3–6, 17, 30, 35, 38, 85, 179
   see also dependence
addictive personality, 44
administration of substances
   see ingestion of substances
adulteration
   see ‘cutting’ drugs
adolescents
   see young people’s substance use
advertising substances, 15, 57, 62, 63
affordability of substances
   see cost of substances
Afghanistan, 51
aftercare
   see follow-up care
age
   implications of, 15, 23, 52, 69
   restrictions on purchase, 53, 57, 62
   see also children and young people, older people
   aggressive behaviour, 25, 196, 201, 203, 214, 245
   see also abuse; crime
agonists, 146–7, 148
Aids
   see HIV
Al-Anon, 214
Alateen, 214
   controlled drinking, 83, 116–17, 168–72, 178, 203, 223, 242
detoxification, 149
   harm reduction, 132–5
   interventions, 116–17, 141, 139–40, 149–151, 184–5, 152–6
   minimum unit pricing, 25, 64
   licensing, 17, 50–1, 63–4, 56, 65, 134, 247
   pharmacological treatments, 149–51
   pregnancy, 209
dangers in withdrawal, 21, 108, 202
Alcohol Abstinence and Monitoring Requirement, 247
alcoholic, 44, 83
   concept of, 3, 4, 17, 30, 37
dementia, 9, 150, 30
   identity as, 34
   see also disease model
Alcoholics Anonymous (AA), 35–7, 83, 87, 164–6
alcoholism
   see disease model
ambivalence, 70–1, 75, 77, 101, 110, 121–2, 125–6, 186
   regarding control of alcohol, 64
America
   see USA
amounts, 19
  assessment of, 105, 106–7
amphetamines, 12, 21, 59, 195, 227
analgesics, 10
anomic, 33
Antabuse (disulfiram), 150, 152, 175
antagonists, 146–7
anthrax, 20
antidepressants, 13
antisocial behaviour, 25, 38, 64, 228, 234
  see also crime
anxiety, 152, 197, 199, 200
  related to substance use, 11–12, 152, 175, 195
arrest, 140, 247
ascorbic acid (vitamin C), 136
aspirin, 10
assessment, 95, 100–15, 139, 223, 252
  children affected by parental problems, 211–13
  children and young people, 231, 232–4
  psychological distress, 199–202
  significant adults, 219–20
AUDIT (assessment questionnaire), 104, 141, 252–4
availability of substances, 24, 31, 53, 62, 64, 229
barbiturates, 9–10
  dangers in withdrawal, 21, 108, 202
barriers
  to engagement, 96, 98, 233, 236, 249
  to recovery, 8, 74, 105, 110–11, 163
behavioural theories of problematic use
  see learning theories of problematic use
benefits of use
  acknowledging benefits, 127
  economic, 51
  in medicine, 51
  personal, 18, 43, 66, 162, 180, 194
benzodiazepines, 10, 23
  detoxification, 152
  pregnancy, 209
  risks in withdrawal, 21, 108, 202
Benzo Fury, 14
benzylpiperazine (BZP), 14
Best, George, 49
bipolar disorder, 200
  and cannabis, 196
binge, 6, 109, 147, 149, 209, 234
  on stimulants, 26, 173, 175
bio-psycho-social theory of problematic use, 47–8, 217, 228
black and minority ethnic communities, 34, 52, 96, 97–8, 220
Black Mamba, 14
black market, 24, 25, 52, 53, 63
blackouts
  excessive drinking, 195
blood borne viruses, 22, 88, 135, 136, 137
  see also hepatitis
BME communities
  see black and minority ethnic communities
Bobo doll, 42
Bolivia, 50
brain, 8–9, 15, 22, 23, 39, 146
  damage to, 150, 195, 209
  see also central nervous system
‘brain disease’
  addiction as, 38
brief interventions, 86, 132, 134, 140–2, 173, 231, 25–4
British system (drug control), 55, 59, 147
buprenorphine (Subutex), 88, 146–7, 148
bupropion (Zyban), 11, 153
BZP (benzylpiperazine), 14
caffeine, 12, 20, 21, 53, 148
Canada
  heroin prescribing, 147
cannabis, 13, 59, 107, 234
  alternative model for regulation, 62–3
  cafes, 63
  as gateway drug, 46
  interventions, 139, 140
  mental health, 13, 19, 194, 195–6, 197
  potential therapeutic benefits, 6, 13, 51
  pregnancy, 209
  use among young people, 227
cannabinoids
  synthetic, 14
care planning, 100, 104, 105, 110, 111, 114–19,
  125, 140, 141, 155–6, 160, 186
  children affected by parental problems, 214
  children and young people, 232–5
  involuntary service users, 242
  psychological distress, 200, 202–3
  significant adults, 220–2, 223
Care Programme Approach, 198
carers
  children as, 208, 214
  kinship, 214
  see also significant adults
cathinones, 14
CBT
  see cognitive behavioural therapy
central nervous system, 5, 8–9, 15, 21, 22, 38–9, 153
Champix (varenicline), 153
change (nature of), 67–78, 87, 92, 122
unassisted, 68–74
see also cycle of change, maintaining change, recovery (capital)
Charles II and coffee houses, 52
‘chasing’ heroin, 11, 22, 136, 137
children affected by parental problems, 25, 57, 61, 72, 92, 96, 112, 206–15, 200
interventions, 213–14
protective factors, 208–9
prevalence, 207
risks, 208
role of adult services, 210–13
children and young people’s substance use
see young people’s substance use
Children of Addicted Parents and People, 214
China
opium wars, 55
Chinese
Oriental flush, 38
immigrants, 52
chlordiazepoxide (Librium), 10, 150
Christians use of wine, 51
chronic relapsing condition, 77, 179
Churchill, Winston, 54
Circle of Care, 163
cirrhosis
see liver
citric acid, 136
classes of drugs
see Misuse of Drugs Act 1971
classical (Pavlovian) conditioning, 23, 39–40, 228
closure of cases
see endings
club drugs (dance drugs), 60, 173
interventions, 176
coca, 50–1
cocaethylene, 11
cocaine, 9, 11–12, 21, 22, 26–7, 60, 107, 136–7, 151–2, 173–6, 195
see also stimulants
Cocaine Anonymous, 164
codeine, 10, 148
coerced into treatment
see involuntary treatment
coffee, 12, 52
see also caffeine
cognitions, 41–42
see also cognitive behavioural therapy
cognitive behavioural therapy (CBT), 87, 139, 154–61, 175, 182–86, 203, 235, 238
cognitive dissonance, 70, 73, 181
collaborative working
see inter-agency working
Community Payback Orders, 247
community reinforcement approach (CRA), 162–3, 175, 224
complimentary therapies, 174, 175
compulsive treatment, 241
see also involuntary treatment
conditional caution, 247
confidentiality, 91, 103, 174, 198, 237
children affected by parental problems, 103, 206, 213
limits of, 103, 242
confrontation, 91, 122, 218
consent
see also voluntary treatment
confidentiality, 91, 103, 174, 198, 237
children affected by parental problems, 103, 206, 213
limits of, 103, 242
confrontation, 91, 122, 218
consent
see also voluntary treatment
controlled drinking, 83, 116–17, 168–72, 178, 203, 223, 242
assessments for, 169–70
controversies, 83
definition, 168–9
programmes, 170–2
controlled drugs
see Misuse of Drugs Act 1971
control of substances
see social policy
cost of substances, 33, 58, 62, 63, 65, 107
alcohol minimum unit pricing, 25, 64
couples therapy, 122, 224
see also marital therapy
crack cocaine, 11, 27, 107, 137, 173, 174–5
cravings, 5, 7, 38, 109, 149, 175
dealing with, 58, 72, 75, 86, 150, 157, 161, 183–4
crime, 24–5, 33, 52, 57, 61, 84, 112–13, 156, 208, 244–8
links with substance use, 244–5
see also criminal justice system
criminal justice system, 55, 63, 244–8, 250
substances as criminal justice issue, 55, 6, 64
see also crime
criminogenic needs, 246
cries and change, 71–2, 77, 176
cues, 16, 39, 40, 156, 161, 180
see also triggers
cultivation of drugs, 59, 62
cultural factors influencing use, 15, 24, 30, 31–5, 50–2, 64
‘cutting’ drugs, 20, 106–7
cycle of change, 75–7, 130, 179
use in assessment, 110, 125, 155
dance drugs
see club drugs
Dangerous Drugs Act 1920, 55
DANOS, 99
Davies, D.L., 83
decriminalisation, 62–3
Defence of the Realm Act (regulations 1916), 55
delirium tremens (DTs), 109, 149–50, 195
demand reduction, 53, 57–58, 64
denial, 4, 7, 36, 91
dependence, 3–6, 38, 60, 74, 104, 145, 169, 252–6
psychological, 5–6, 26–7, 228
see also addiction, under names of substances
depressant drugs, 8, 9–10, 21, 45, 108
dangerous in withdrawal, 108, 202
overdose, 23, 146
see also under names of substances
depression, 108, 199, 200–1, 202
effect of substances, 11, 152, 175, 194, 201
deprivation
see social disadvantage
detoxification, 4, 7, 21, 86, 109, 117, 118–19, 145–6, 152, 248
alcohol, 149–51
benzodiazepines, 152
GHB/GBL, 176
nicotine, 153
Opiates, 148
deviance theory, 34–5, 74, 231
diaries, 105, 141
diazepam, 10, 150, 152, 245
see also benzodiazepines
dihydrocodeine, 11, 148
disease model
see theories of problematic use
disulfiram (Antabuse), 150, 152, 175
diversionary activities, 231, 238
risks of, 54
diversion from prosecution, 247
diversity
see also BME
domestic abuse
see abuse
dopamine, 9
drink driving legislation, 53, 134
drinking
see alcohol
‘drug, set and setting’ (Zinberg), 8, 14, 19, 47, 171
drug courts, 247
Drug Rehabilitation Requirements, 247
drug testing, 162, 247, 250
Drug Treatment and Testing Order, 247
Drug Treatment Outcomes Research Study (DTORS), 250
drugs
definition 4–5, 8–9, 14–16
social policy, 24, 53–7, 59–63, 65, 84–5, 246–7
see also under names of substances
DTORS (Drug Treatment Outcomes Research Study), 250
DTs
see delirium tremens
dual diagnosis
see psychological distress
ecstasy (MDMA), 12, 18, 19–20, 21, 51, 228
mental health risks of, 12, 195
education
regarding substances, 53, 57, 226, 230–1
empathy, 89–90, 126, 211
employee policies, 240, 242–4
effectiveness of, 249–50
interventions, 248–9
endings, 94, 178, 187–8, 237
energy drinks, 21
England, 173, 246
adolescent use, 227
alcohol policy, 64
blood borne virus rates, 133
children affected prevalence, 207
court disposals, 247
Fraser guidelines, 237
heroin prescribing, 147
mental health services, 198
environment, 43, 75, 180
influence on change, 71–2, 110–11, 161–3
influence on use, 8, 14–16, 31–3, 35
relapse, 182, 184
risks, 19, 23, 24–5
epidemics, 32, 55, 58, 60, 66
epilepsy
see seizures
escape coping, 44
ethnic communities
see black and minority ethnic communities
European countries
challenge to unit pricing of alcohol, 64
heroin prescribing, 147–8
European Union
directives on tar levels, 58
evidence (methods of obtaining), 82–3
expectation regarding use, 8, 14–15, 21, 180, 182
family’s involved in treatment of
an adult, 84, 103, 146, 150, 162–3, 175, 216, 222–4
a young person, 235, 236–8
family therapy, 214, 218, 224, 235
fetal alcohol spectrum disorder, 209
five step method, 221
flash cards, 183
follow-up care, 82, 140, 187–8, 239
four Ls (Roizen), 26
FRAMES (acronym), 141
Fraser guidelines, 237–8
freebase (cocaïne), 107
French drinking habits, 24
gateway theory, 45–6, 138
GBL (gammabutyrolactone)
see GHB
genes, 38
see also genetic theories
genetic theories
see theories of problematic use
geography (availability of substances), 50–1
Getting our Priorities Right, 207
GHB (gammahydroxybutyrate), 9, 10, 110, 137, 176
risks in withdrawal, 21, 108, 202
Global Commission on Drug Policy, 62
goal setting
see care planning
Great War, 55
Greece
HIV increase, 133
group work, 214, 231, 235
guided discovery, 158–9, 183
Hague International Opium Convention, 55
hallucinogens, 8, 12–13, 14, 33, 52, 59, 209
also see under names of substances
harms, 18–28
see also under names of substances, individual chapters in Part 111 Special Populations
harmful use (WHO definition), 6, 18–19, 141, 252
harm reduction
as individual intervention, 101, 116, 132–9, 174, 202, 234
as social policy, 53, 55, 58, 59, 60, 61, 84
hazardous use (WHO definition), 6, 19, 141, 252
Health Act 2009, 57
hepatitis
A and B, 137
C, 61, 107, 133
see also blood borne viruses
interventions, 87, 88, 146–9, 152, 155, 175, 186, 245
pregnancy, 209
prescribing, 63, 147–8
see also opiates
Hidden Harm, 207
HIV, 60, 61, 84, 97, 107, 133, 174
comparative rates, 133
Holland
drug policy, 61
cannabis cafes, 63
human growth hormones, 137
image-enhancing drugs, 22, 137
Improving Access to Psychological Therapies, 199
infections, 20, 107, 136
information
providing to service users, 112, 115, 134–7, 168, 187, 212, 221, 241
ingestion of substances
methods of, 14, 19, 22, 34, 46, 209
harm reduction, 133, 135–138, 145
initiation into use, 31, 58, 167, 228, 229, 238
injecting, 22, 60, 123, 174, 176
harm reduction, 134, 135–7, 145, 147
risks, 22, 23, 108, 234
see also individual drugs
injecting rooms, 63
inter-agency working, 95, 100, 103, 115, 144, 198, 249
regarding children affected by parental problems, 206–7, 209, 210, 212–214
Internet
- diaries on, 105
- information from, 134
- forums and therapeutic sites, 167, 168, 214
- sales of drugs, 63, 65
- involuntary treatment, 115, 240–51
- criminal justice system, 246–8
- employee policies, 242–4
- evidence of effectiveness, 249–50
- interventions, 248–9
- Iranian revolution, 60
- Islam
  - prohibition, 17
  - isolation (social)
- Japanese
  - Oriental flush, 38
- Jellinek’s types of alcoholism, 36–8
- Jewish people
  - alcohol use, 31, 32
- junkie
  - stereotype, 4
- ketamine, 8, 13, 173, 176, 201
- khat, 52
- Kinder eggs, 107
- kinship carers, 214
- Koreans
  - Oriental flush, 38
  - Korsakoff’s syndrome, 19, 150, 195, 204
- labelling, 73–4, 122, 167, 231
  - theory, 34–5
  - see also stigma
- lapse
  - see relapse
- lead professional, 115
- learning theories of problematic use, 39–43, 156, 160–1, 245
- legal highs
  - see new psychoactive substances
- legalisation debate, 61, 62
- legislation, 16, 53, 55, 61
  - alcohol licensing, 63, 134
  - Dangerous Drugs Act 1920, 55
  - Defence of the Realm Act (regulations 1916), 55
  - drink driving legislation, 53, 134
  - Health Act 2009, 57
  - Licensing Act 2003, 64
  - minimum unit pricing alcohol, 25, 64
  - Misuse of Drugs Act 1971, 8, 17, 59–60, 103
  - Pharmacy Act 1868, 54
  - Tobacco Advertising and Promotion Act, 2002, 57
  - Tobacco and Primary Medical Services (Scotland) Act 2010, 57
  - lesbian, gay, bisexual and transgender community, 97
  - less intensive treatment, 86, 132, 139–40, 254
- LGBT
  - see lesbian, gay, bisexual and transgender community
- Librium (chlordiazepoxide), 10, 150
- licensing
  - alcohol, 63, 134
  - models for drugs, 62
  - see also legislation
- Licensing Act 2003, 64
- liver, 5, 8–9, 11, 15
  - damage, 9, 15, 19, 23, 24, 26, 56, 108
  - function test, 107
- lofexidine, 148
- loss of control, 36–7, 38, 182
- LSD, 12, 13, 24, 51
  - psychological distress, 195, 201
- lung cancer, 19, 57, 58
  - see also cycle of change
- manuals, 94–5, 123
- mapping tools, 95, 105, 184
- marital therapy, 139
  - see also couples therapy
- matching, 89
- maturation out of problematic use, 69, 235
- MDMA
  - see ecstasy
- menstrual cycle, 15, 108
- mental health
  - see psychological distress
- mentoring, 214, 218, 239
- mephedrone, 14, 173, 176, 227
- methadone, 10–11, 61, 63, 84–5, 88, 109, 146–7, 148
- methamphetamine, 12, 173
- methoxetamine, 14
- methylphenidate (Ritalin), 11
- Mexico
  - drug trafficking, 25
  - native people’s peyote, 51
- minimum unit pricing alcohol, 25, 64
- misuse, 8
INDEX

Northern Ireland
Fraser guidelines, 237
mental health services, 198
court disposals, 247
Norway
snus, 138
novice user, 228
obsessive compulsive disorder, 13, 200
offenders
see crime
older people, 15, 23, 52, 69, 108, 138, 166
operant conditioning, 40–1, 43, 69, 228
opiates, 10–11, 45, 54–6, 59, 108, 117, 146–9, 152
detoxification, 148
harm reduction, 134–8
pregnancy, 209
substitution therapy, 88, 117, 145, 146–7, 133, 186
see also under names of substances
opioids
see opiates
opium, 54–6
Oriental flush, 38
outcomes (measuring)
treatments, 82, 234
predicting, 86
social policy, 56–7
outlets (sales), 62–3
outreach, 97, 98, 133, 134, 135, 174
overdose 20, 23, 24, 105, 146, 147, 223, 248
reducing risk of, 134, 135, 137
see also individual drugs

packaging
of cigarettes, 57
alternative drug regulation, 62, 63
painkillers (prescribed), 65, 105
pain reducing drugs, 8, 10–11, 21, 23
see also under names of substances
panic attacks, 200
cannabis, 13, 195
Papago people, 15
paracetamol, 10, 20, 136
paranoia
related to substance use, 11–12, 108, 174, 195
parental substance problems
see children affected by parental problems
passive smoking, 57, 58
Pavlovian conditioning
see classical conditioning
peer group influences, 31, 42, 46, 170, 226, 229
peer support, 85, 96
see also mutual aid groups
permission giving thoughts, 158, 160, 183
pethidine, 10
peyote, 51
pharmacological treatments, 86, 144–54, 223
alcohol, 149–50
benzodiazepines, 152
nicotine, 142, 153, 238
opiates, 146–7
stimulants, 151–2
young people, 237, 238
see also substitute prescribing
Pharmacy Act 1868, 54
phenethylamines, 14
phobias, 200
physical abuse
see abuse
piperazines, 14
polydrug use 7, 21, 65, 106, 150, 173, 227, 233
see also mixing substances
post traumatic stress, 45, 199, 200
see also trauma
poverty
practitioner skills, 89–94, 123–4, 140
pregnancy, 96, 106, 108, 109, 148, 150, 170, 208, 209, 212, 249
prescription drugs, 65, 194, 196, 203
and psychological distress, 108, 203
see also under names of substances
price of substances
see cost of substances
prison, 135, 247–8
Probation Order, 247
prohibition, 17
alcohol in USA, 56
drugs, 59–62
Project Match, 89, 164
psychoanalytical interventions, 87
theories of problematic use, 43–5
psychological distress, 19, 107–8, 117, 150, 176, 193–205, 220, 233
interventions, 145, 169, 199–204
links with substance use, 44, 193–6
prevalence, 197
services, 197–9
see also under individual substance names
psychosis, 196, 200–1, 202, 203, 204
drug induced, 12, 152, 195, 201, 202
psychostimulants
see stimulants
Public Health England, 61
purity of drugs
see ‘cutting’ drugs
questions, types of
closed, 92–3, 101, 113, 127, 158
leading, 93, 127, 158, 200
open, 93, 101, 127
Rand report, 83
Rastafarians, 52
rational choice (moral) model of problematic use, 46–7
Rational Emotive Behaviour Therapy, 167
rebellion
substance use as, 33–4, 52, 59
recapping
see summarising
recession
effects on substance use, 65
recovery, 8, 60, 61, 84–5, 133, 144, 164, 167, 204, 224
capital, 72, 73, 77, 86, 110–11, 146, 187
movement, 77, 84–5, 179
unassisted, 67–74
and young people, 239
recovery groups
see mutual aid groups
recreational use, 7, 51, 173, 228
reframing (technique), 126, 127
refusal skills, 72, 76, 171, 176, 180, 184–5
rehab
see residential rehab
relapse, 7, 75, 77, 146, 161, 178–86, 188, 223–4
pharmacological treatments to prevent, 145, 148–9, 150–1, 152, 153
prevention, 43, 72, 75, 87, 95, 110, 175, 182–6, 203
relatives
see significant adults
religion
influences cultural attitudes, 51
as part of recovery, 72
reproductive health, 108, 138
residential rehab, 87, 89, 117–8, 164, 175, 203, 214
resistance to change, 91, 101, 122, 126, 127, 241
reviews of cases, 86, 101, 103, 116, 155
risk-need-responsivity model (criminal justice), 246, 248
risks of use, 18–28, 134–9, 194–6, 228, 144–5
to children, 207–9
to significant adults, 217–18
see also under names of substances
Ritalin (methylphenidate), 11
ritual of substance taking, 40
‘rock bottom’, 36, 122
Roisen’s four Ls, 26
role play, 96, 161, 171, 185, 235
Rolleston Committee, 55
Romania
HIV increase, 133
Russia
HIV rates, 133
SADQ-C (assessment questionnaire), 104, 109, 252, 254–6
same sex counsellors, 97
schizophrenia, 194, 200
possible links with substance use, 19, 195–6
schools
see education
Scotland, 25, 51
adolescent use, 227
alcohol policy, 64
Fraser guidelines, 238
mental health services, 198
court disposals, 247
seemingly irrelevant decisions, 180–1, 183
seizures (in withdrawal), 21, 108, 109, 149–50
selective serotonin uptake inhibitors, 152
self efficacy, 42, 71, 126, 141, 161, 164, 180, 181, 182
self help groups
see mutual aid groups
self medication, 44, 194
self motivational statements, 127
see also motivational interviewing
service culture, 95–8
sexual abuse
see abuse
sexual and reproductive health, 108, 138
sex work, 96, 108
siblings
effects on, 25, 216, 218
significant adults, 87, 103, 163, 199, 203, 216–25
5-step method, 221
involvement in service design, 199, 223
involvement in treatment of substance user, 216, 222, 223–4
meeting own needs, 216–23
single shared assessment, 103, 104, 144
slogans
Alcoholics Anonymous, 166, 182
SMART criteria (acronym), 115
smart drugs, 65
SMART Recovery, 167, 168
smoking
see tobacco
snorting drugs, 11, 19, 137
snuff, 11, 51
snus, 138
Social Behaviour and Network Therapy, 162–3, 224
see also community reinforcement approach
social disadvantage, 30, 31, 33, 60, 73, 174, 208, 209, 229
social learning theory, 42–3, 69, 181
social policy
alcohol, 63–4
drugs, 59–61
historical, 54–6
judging effectiveness of, 56–7
methods of control, 52–4
tobacco, 57–8
social networks, 72, 162–3, 164, 175, 223, 235
sociological theories of problematic use 31–5
Socratic questioning (see guided discovery)
solvents
see volatile substances
Somali people
khat, 52
speedball, 22
speed
see amphetamines
spontaneous change
see unassisted recovery
stabilisation
steroids, 5
injecting, 22, 136–7
stigma, 4, 34–5, 73–4, 85, 173, 193, 217, 231
see also labelling
stimulants, 8, 11–12, 14, 21, 45, 117, 227
come down (withdrawal), 11, 152, 175
harm reduction, 134–7
interventions, 173–6
psychological treatments, 151–2
psychological distress, 152, 175, 176, 195, 201
prevalence, 173
see also under names of substances
stimulus control, 76
strain theory applied to problematic use, 33–4
Suboxone, 147
substance
substances
substitute prescribing, 138, 145, 237, 248
controversies, 61, 84–5, 88
for opiates, 88, 117, 145, 146–7, 133, 186
for stimulants, 151
for tobacco, 142, 145, 153, 238
Subutex (buprenorphine), 88, 146–7, 148
suicide
prevention, 108, 199
risk of, 150, 152, 176, 196, 199, 201, 202
summarising (technique), 90, 104, 127, 158
supply reduction, 53, 56, 57, 64
Sweden
drug policy in, 61
snus, 138

tanning agents, 137
taxation of substances, 53, 57, 62
temazepam, 10
temperance movement, 56
Temporary Class Drug Orders, 60
testing
see drug testing
Thatcher government
harm reduction, 60
recession, 65
theories of problematic use, 29–49
bio-psycho-social theory, 47–8, 217, 228
disease model, 7, 35–7, 83, 87, 122, 164, 169, 182
gateway theory, 45–6, 138
genetic theories, 23, 35, 37–9, 245
learning (behavioural) theories, 39–43, 156, 160–1, 245
psychoanalytical theories, 43–5
rational choice (moral) model, 46–7
sociological theories, 31–5
therapeutic alliance, 86, 89–91, 155
thiamine (vitamin B1) deficiency, 150
Thorley, Anthony, 101, 211, 241
model, 26–7, 105
thought stopping, 183
tier model of services
for adults, 98–9
for children, 230–1
titration, 147
tobacco, 11, 19, 21, 22, 35, 44, 52, 74, 195, 228, 229
harm reduction, 53, 58, 133, 138
interventions, 142, 145, 153, 238
passive smoking, 25, 57, 58

pregnancy, 209
social policy, 53, 56, 57–8
Tobacco Advertising and Promotion Act 2002, 57
Tobacco and Primary Medical Services (Scotland) Act 2010, 57
tolerance, 5, 23, 24, 109, 135
see also under names of substances
tramadol, 148
Transform, 62
Transtheoretical model
see cycle of change
trauma, 105, 117, 156
see also post-traumatic stress
treatments
see under individual interventions
triage, 95, 96, 102
triggers, 7, 105, 121, 184
for change, 71–2
twelve steps
see 12-steps
UK Alcohol Treatment Trial (UKATT)
see Social Behaviour and Network Therapy
unassisted recovery, 68–74
unintended consequences
social policy, 53–4
USA
international control of drugs, 55
native people’s peyote, 51
prescription painkillers, 65
prohibition (alcohol), 56
Vietnam war, 32
user involvement, 71, 96, 135
Valium
see diazepam
varenicline (Champix), 153
vicarious learning, 42
Vietnam
US soldiers and heroin, 31–2
vitamin C (ascorbic acid), 136
vitamins, 150
volatile substances, 7, 8, 10, 227, 228
Wales, 173, 246
alcohol policy, 64
court disposals, 247
Fraser guidelines, 237
mental health services, 198
websites
see Internet
welcoming gesture, 102, 233
Wernicke’s encephalopathy, 150, 195
Wilson, Bill, 36
Winehouse, Mitch, 3
withdrawals, 5, 6, 20–1, 41, 108, 145, 202, 209, 256
alcohol, 109
benzodiazepines, 110
GHB/GBL, 110
opiates, 109–10
substances dangerous in withdrawal, 21, 108, 202
see also detoxification
women, 34, 149
services, 96–7, 165
see also pregnancy
workplace policies
see employee policies
wraparound services, 85, 99, 117, 177, 187, 203, 214
young people’s substance use, 23, 226–39
assessment and care planning, 232–5
interventions, 235–9
prevalence, 227
protective factors, 230
risks, 228–9
services, 230–2
Zinberg’s ‘drug, set and setting’, 8, 14, 19, 47, 171
Zyban (bupropion), 11, 153