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Public health and human rights: accepted or denied?

Readers will recall DAT Issue 2, 2017 which covered the proceedings of the 2016 UNGASS; and the subsequent collection of essays “Collapse of the global order on drugs” published in 2018. Core to both publications and the 2016 UNGASS on drugs are the regular meetings of the Commission on Narcotic Drugs (CND), held under the auspices of the UN Office on Drugs and Crime in Vienna. Ostensibly designed to monitor the workings and impact of the International Drug Control Conventions[1], CND proceedings have increasingly operated as a forum for contrasting, opposing and, more and more, irreconcilable views and attitudes on the Conventions. Prior to the March 2019 62nd session of CND, there was a two-day High-Level Review of the Conventions. Taken together, the two events represented six days of discussion, debate and position-stating – not to mention denouncement, denial and refusal to recognise the sovereignty of states whose ideas were not in alignment with some of the nations represented.

As a first-time attender at the UN City in Vienna, my initial impressions of the site and the event were of open-ness and accessibility. Once inside the complex of UN buildings, after passing through airport-style security where the only interventions I observed by the UN’s security staff (all armed with side guns) were reminders and requests to put away mobile phones in the security check area, pass holders had unlimited access to the whole site and complex. The UNODC building consists of meeting rooms of various sizes and shapes; offices for the permanent staff – and corridors […]. Whether occupied or not, these offices were almost without exception characterised by open doors. Display screens gave details of events and rooms, with one or two events shown as “closed”. The larger rooms – room is something of an understatement – were equipped with simultaneous translation facilities for the UN languages. The only occasion on which I was stopped and checked was when the photograph and name side of my pass was not visible when I was about to enter the large room where the plenary sessions were held during the two days of the High-Level Review.

Style over substance: enforcement vs treatment

This initial impression of open-ness stayed with me till the second day, when I realised that the two days during which I was listening to national delegations stating their positions and policies were, effectively, sterile activities, with the appearance of “debate” being gone through: the defining Ministerial Declaration had been announced on Thursday morning, at the start of the week’s proceedings. So any expectations that the week would truly comprise monitoring, let alone review, were quickly dispelled. Colleagues with more experience of CND were too kind to comment on my naïvety, but this failure to include any genuine review of the Conventions and their real-world impacts was but one example of the Newspeak approach to language which I increasingly observed during my five days observing proceedings and talking to others (I was not present at the first Monday, the day of CND itself). As the official delegations’ statements followed one another, I became aware that many of the speakers were wearing police or military uniforms, or had military titles. As I attended the CND events the following week, I also noted the male–female discrepancies: the majority of those who spoke as official delegations during the two High-Level Review days were male, while the NGO and CSO organisations had a high ratio of female members, speakers and meeting convenors.

So what is the purpose of the High-Level Review? Given that the outcome is published before any events have taken place, it is clearly not designed or intended to benefit from the impressive array of events and meetings which took place during the five CND days. As the introductory
chapter of “Collapse of the global order on drugs” suggests, many of the official delegations adopted a stance which seemed more suited to demonstrating a presence on the international stage at which power and status could be paraded rather than to outline their nation’s evidence-based approach to drug policy. As the two High-Level Review days rolled on, I became more interested in observing nations’ and speakers’ stances, language and attitudes rather than the content of their speeches.

However, alongside the frustratingly predictable references to “the world drug problem”, descriptions of drug use (and users?) as a “scourge” from, amongst others, China, Japan, Myanmar, the Russian Federation, Singapore and the USA, there were more thoughtful and reflective contributions from, amongst other nations, Canada, Chile, Colombia, Ecuador, Ireland, Mexico, Slovenia and Uruguay. My list is weighted to countries where “the war on drugs” has actually been fought, so they speak with the authority and first-hand knowledge of the effects of a prohibition and enforcement interpretation of the Conventions. In its speech, the USA took the opportunity to verbally attack Venezuela, not for its drugs policies. The US speaker ended her presentation by stating that “We are never as strong alone as when we are working together”. This statement was regarded with scepticism by my two female neighbours: one from Colombia, one from Canada. I also found it at odds with “America first” sloganising, a nationalist and protectionist attitude shared with other nations. During the CND days, the Russian Federation denounced Canada for its “violation of international law” by legalising the recreational use of cannabis. In contrast, the Irish Minister for Health stated that “Our drug policy is based on compassion and humanity”, and speakers from several Latin American countries referred to the need for land reform.

The official UK position was put by a Home Office civil servant, who referred to international co-operation and the UK Crime Agency. This follows the first-time inclusion of a section on global activity in the UK drug strategy from 2017, possibly positioning for a post-Brexit “global Britain”. The principal UK Government contribution to the CND side-events was a session on law enforcement and organised crime. Some states seemed to deny any domestic use of illicit drugs, seeing their place in the drugs trade as transit routes and their roles as subject to the activities of international organised crime. There was a reluctance of such states to acknowledged their own domestic roles as growers, producers, exporters and users of illicit drugs. The number of references to evidence-based practice and to gender equality was striking, not least because many such statements were made by nations whose poor human rights practices and lack of equality between the sexes have long been documented by NGOs and civil society organisations (CSOs).

Where to in drug control? Between the CND 2009 declaration and the UNGASS 2016 outcome document

It was also becoming clear that there is a divide between national delegations and statements which emphasise the CND 2009 political declaration; those which emphasise the 2016 UNGASS Outcome Document; and the UN’s own Sustainable Development Goals. The UNGASS Outcome Document made important concessions to and inclusions of public health and human rights approaches to drugs policy, including the acknowledgement of harm reduction. “Harm reduction” had been a taboo term in the 2000s, and it was one of the achievements of CSO participation at UNGASS and other events to make the term, the practice and the usage recognised and accepted at the international fora. It was interesting to note which states prioritised the 2009 document over the 2016 document, which was intended to update and move-on interpretations of the Conventions, even though the proceedings and declarations of UNGASS out-rank those of UNODC. The UN itself has written this year on the “hierarchy” of events and their priorities[2].

Two of my foci from the events and discussions were on the role of CSOs; and the position of tramadol. The (previously submitted and selected written) question-and-answer session with the Director of UNOCD during the CND days included the issue of CSOs. Yuri Fedotov emphasised that CSOs alone cannot change or amend the Conventions. However, their inclusion in official delegations, which have the power to change and amend the Conventions, was acceptable and one way in which the CSO and user voice could be better heard and acted on. Tramadol was a
frequent topic in both the High-Level Review sessions and the CND events the following week. Part of its “presence” was in contexts where its value as an analgesic and an essential medicine was accepted and developed. This acceptance was clearly not shared by all official delegations, some of whom continued to call for tramadol to be “controlled” (more Newspeak) under the Conventions in spite of its value as a pain killer. For many, the response to tramadol seemed to be used as a litmus paper to show a strong and unshakeable stance on illicit drugs, regardless of the cost to health services and individuals. Many of those nations pointed to the claimed “abuse” of tramadol, on their territories and elsewhere, and used this as their basis for arguing for controls. Evidence from the WHO Expert Committee on Drug Dependence was dismissed by such nations, often on the grounds that it was “insufficient”, an argument which sounded to me like kicking the can down the road as a tactic to avoid acknowledging and accepting the many medical benefits of the drug and the supporting evidence. It also seemed that the opposition to tramadol as a substance being abused misunderstood or misrepresented tramadol. Where “tramadol” is being misused, it is a different substance to pharmaceutical quality tramadol – street tramadol? – and is at a far remove from the “real” thing, being subject to dilution, adulteration, cutting or simply not being “tramadol” at all. This failure or refusal to accept the extensive evidence of the nature of the trade in illicit drugs – what is sold as tramadol is not necessarily tramadol – continues to mean that some states seek to ban and control pharmaceutical tramadol in the mistaken belief that doing so will impact the trade in illicit tramadol: the two substances are completely distinct.

This confusion, whether deliberate or arising from a lack of understanding, which is increasingly inexcusable, given the extensive evidence around the trade in pharmaceutical and illicit tramadol, also runs in opposition to the much-resorted to Conventions’ texts. The 1961 Single Convention on Narcotic Drugs starts with a preamble whose first two items read: “The parties […] Concerned with the health and welfare of mankind; Recognizing that the medical use of narcotic drugs continues to be indispensable for the relief of pain and suffering and that adequate provision must be made to ensure the availability of narcotic drugs for such purposes […]”. Along with the casual misuse of references to evidence-based policy, human rights, gender sensitivity and national sovereignty, the wording of the Conventions is prey to a range of interpretations. Here it is “the health and welfare of mankind”, the opening statement of the Preamble to the 1961 Single Convention. The range of interpretations and understandings of “health and welfare” as they apply to drug policy indicated by the statements of the official delegations extend from treatment and care though imprisonment to extra-judicial murders and judicial executions. Here, again, the divide between nations championing the UNGASS Outcome Document and the SDGs, and those preferring the 2009 Political declaration, was brutally evident.

Notes


No end in sight: the international drug control system once again baulks at the prospect of reform

Klein Axel and Blaine Stothard

Abstract

Purpose – In two separate sections the authors summarise the observations, use the insights to reflect on some of the propositions made in the book, and follow the appeal of one of the authors to civil society and academics to “help governments out of the drug policy dilemma that is now facing them”. The paper aims to discuss this issue.

Design/methodology/approach – The genre the authors follow here is ethnography and the material takes the form of reflective field notes. Since each author follows a particular set of interests the authors split the paper into two sections. There are no strong conclusions, safe that the concerns about the international drug control system were fully borne out by events on the floor.

Findings – The role of CSOs is critical in moving the process forward – but countries are likely to drift apart as the policy differences are becoming irreconcilable.

Research limitations/implications – It is imperative to develop new models of cooperation in the management of psychactive substances.

Practical implications – This is in recognition that at national level just as much as at Commission on Narcotic Drugs (CND) and UN General Assembly Special Session the increased involvement of CSOs has been pivotal in shifting focus towards public health and human rights. This in turn has encouraged some nations to do the same in their domestic policies – and to stand up and say so in CND meetings.

Social implications – More involvement of academics and editorial teams in the design of sustainable policies and practices.

Originality/value – In a critical report on the CND the authors challenge the viability of the international drug control regime in view of the emerging differences between different member states. This is the first attempt in the drug policy literature to assess the durability of the drug control regime as it is faced by the fast paced transformation of cannabis into a recognised medicine and regulated recreational substance. If the appearance of agreement is maintained this is entirely for diplomatic reasons and organisational benefit. In reality, the system is breaking apart and new methods for regulating drugs are emerging.

Keywords International drug policy, Drug control conventions, CND, Ethnographic observation, Policy process, Tramadol

Paper type Technical paper

In December 2018 the DAT editors launched a collection of articles under the title Collapse of the Global Order on Drugs: From UNGASS 2016 to Review 2019. The premise of the book was that the current drug control system was no longer working or workable and that it was destined to collapse as a functioning, rational, international system. We further argued that if it were set to continue in its current form it would only serve to discredit the international order. The mild optimism that spread after promising talk of human rights and development goals at the UN General Assembly Special Session on Drugs (UNGASS) in 2016, was always moderated by a realistic appraisal of the benefits governments could draw from adherence to the treaties. In mid-March the editors set off for Vienna to attend the Commission on Narcotic Drugs (CND) in person, observe proceedings in the plenary and participate in the side events that, mostly organised by civil society, have added an entirely new energy and level of informed debate to these events.

In two separate sections we summarise our observations, use our insights to reflect on some of the propositions made in the book, and follow the appeal of one of the authors to civil society and...
academics to “help governments out of the drug policy dilemma that is now facing them” Trace (2018).

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1. Public health and human rights: accepted or denied?

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2. Understanding the organic purpose of CND – agency promotion for international drug control and extending the powers of national security systems

CND as a showcase for drug control agencies

The tall UN towers converge onto a rotunda which for these few days has the busy appearance of a market fair. Along the walls officials show off their governments’ valiant efforts at combating the drug scourge (sic) to conference participants and UN employees, who pass by on route to the canteen. Leaflets, posters and plastic give-aways put a cheery gloss on some pretty grim business. The stall of the Islamic Republic of Iran, record holder for official executions for drug offences, is close to that of the Philippines Drug Enforcement Agency, the leader for non-official ones. Between them, right in the centre of the space, the Kingdom of Saudi Arabia has a tent offering the hospitality that its diplomatic missions are renowned for. Further along, a Norwegian NGO has set up a stall campaigning for de-stigmatisation, while on the plaza a group of campaigners are calling on all delegations to “support don’t punish”. But most exhibition space is taken by the United Nations Office on Drugs and Crime (UNODC), on their home ground as co-organisers and prime animator of this entire show. For a UN agency that was created to combat the evil of drugs, the annual get together of drug control delegations is the equivalent of Holy Week.

A quick review of some of the wares that we collected in one short stroll between the sessions, helps to underline the simple futility of trying to hold together a system conceived by dreamy idealists and bureaucratic empire builders. I picked up “Run Totoy”, a “Drug Abuse Prevention
Comic from the Philippines, that opens with a message from president Rodrigo Duterte and ends with agents Phed and Eya arresting the gang of drug dealers. A little later a colleague from an advocacy network gave me copy of Cannamo, a Spanish magazine dedicated to the art and science of cannabis cultivation. Next, I got hold of the West African Model Drug Law, an attempt crafting a tool to avoid the mass criminalisation of the young.

Cannabis, pictured in seductive greens and purple on the pages of Cannamo, with detailed tasting notes for the connoisseur, is no laughing matter in Manila, where law enforcement offices (like Phed and Eya) have a licence to kill smokers of cannabis or any other scheduled substance. The measures used in the Philippines may be excessive, but they get tacit support from member states from across Asia and the Middle East. It is not human rights or public health that the meeting has come to protect, but the international treaties and the system that has been built on its foundations. Neither the graphic weed porn of Cannamo nor the billion dollar listings of cannabis companies on the Toronto Stock Exchange (TSX) are a laughing matter. The Russian delegate, speaking neither with notes nor the polite tact that usually prevails in these dignified meetings, accuses Canada of posing a global threat and that there should be consequences.

In the corridors, veterans shrug this off as histrionic, a quid pro quo for Canada’s strongly voiced objections to Russia’s occupation of Crimea. Cynics may have a point, and yet these open attacks on the new cannabis regime are loudly applauded. It is not the substance of these reforms or their impact on human health that is being considered, but their erosion of the punitive principle. Even though the purpose of the drug control system is to further public health, the delegations of most counties are led by, and sometimes consist entirely of, members from national security and law enforcement services. Even when the ministry of health is part of the team this is in symbolic adhesion to the principle of the “balanced approach”. Drugs, according to the Russian ambassador, is what the road to hell is paved with. Extinguishing their use requires all the force the state has at its disposal, regardless of collateral damage.

The drug control treaties provide an elegant international frame for the most appalling mix of crude repression, unchecked bureaucracy and blatant corruption. They have been the foundation of an ever-growing regime of controls and checks that have significantly reshaped social, economic and political life. At one end it lends cover for making it more difficult for citizens to access their banked savings (Anti Money Laundering), at the other it impedes the trade in pre-precursor chemicals that go into the making of cocaine or the so called New Psychoactive Drugs. And access to essential medicines?

Unable to either quell demand or intercept the supply, the control system has called into being a teeming “netherworld” of criminals and opportunists profiting from market distortions and price discrepancies, whose ever more sophisticated operations have generated an exponential increase in drug offenders[2]. For the control bureaucracies this is has been a feast, with UNODC, a behemoth with over 500 permanent and a multiplicity of short-term staff in over 20 country offices, alone enjoying a budget of US$320.6m in 2017.

Yet because only US$22.4m are core funding, the agency is perpetually hungry, always on the look-out for new projects to implement. These meetings are critical, then, for “raising alarm” about imminent crises, drawing attention to emerging issues, creating awareness on problematic trends. The unexpected boon for all beneficiaries of the drug control industry, is that each turn of the prohibitionist screw has generated new sets of problems that a different part of the agency can then jump in to fix.

For example, during the 1990s much of the work of the agency was getting countries to adopt the three drug control Conventions and incorporate their provisions into national legislations. Teams of UNODC lawyers were working their way across the world with blueprint laws that would be translated and written into national codes. One sharp consequence in countries stretching from Georgia in the Caucasus to Guyana on the north-eastern tip of South America was a sharp rise in prison populations. In some jurisdictions it would appear as if the main purpose of the prison complex is for storage of drug consumers, with little effect on public safety or crime levels. But overcrowded prisons have opened new lines of UNODC business: prison health, alternatives to incarceration and post-release after-care. The agency even has a programme, set up with funding from the government of Qatar, to produce a global brand for products made in prisons by...
prisoners. According to one of the consultants drafting guidance, the “one hand of the organisation is encouraging member states to lock people up while the other is training them ways of avoiding incarceration”[3].

**Essential medicines – withhold and supply**

This year’s big business opportunity lies in assisting countries in accessing essential medicines. Medical doctors in low- and middle-income countries, and more pertinently, their patients, find getting hold of powerful pain medication nigh to impossible – thanks to the rigorous enforcement of the drug control Conventions. For the past fifty years, the International Control Board has placed a heavy emphasis on preventing diversion to non-medical use by reducing the flow of morphine-based medicines to a trickle. The consequences are stark. In the West African country of Niger, for instance, patients going into surgery are informally instructed to bring their own medicine as the hospital pharmacy rarely has morphine in stock[4]. Across Africa and Asia patients suffering from cancer, HIV or such excruciating diseases as sickle cell anaemia, are routinely palmed off with paracetamol and ibuprofen[5].

The reason for this extraordinary discrepancy of access to pain medication is the drug control system and its rigorous enforcers. All national authorities have to report their annual requirements to the International Narcotics Control Board without whose permit they will find it difficult to contract the services of a respectable international medicine supplier. As a consequence, the market has been opened to producers and traffickers of knock-off products – what the WHO calls Substandard/Spurious/Falsely labelled/Falsified/Counterfeit – that have since flooded into African market. So UNODC and INCB are now preparing programmes to assist national authorities in estimating need and ordering the good stuff, just as other nations are pressing hard for tramadol, the last remaining available stage two opiate, to be placed in the international schedules (World Health Organization, 2017).

If the self-seeking work of control bureaucracies is persistent, predictable and inevitable, their existence remains predicated on the interest of the UN Member States. Theoretically at least there is a democratic dynamic at work, as tax dollars (the US dollar is the currency used by UN accounting systems) are awarded by national governments, ostensibly representing the will of their electorates. But inside the “enchanted palace” the space for the people is restricted to a few seats in the press gallery. On the floor of the plenary hall, the national delegates make sure that they retain control over the process. They give short shrift to the recommendations of the World Health Organisation for cannabis to be moved into a less restrictive schedule, and Cannabidiol (CBD) taken out of the international control altogether. For China and the USA there needs to be more time to consider. Ironic, really, since well over half the US population already have ready access to any of these products. If they happen to be living in one of the 30 states permitting the distribution of medical marijuana, they even enjoy quality control.

Yet the CND collectively claims to need more time to reflect on the merit of a proposal that basically asserts that cannabis is less harmful than heroin and could be moved to a schedule that more accurately reflects this. According to a lone voice from Uruguay there is actually no need for further consideration at all because the case has long been made. But at a gathering of prohibition advocates scientific evidence is only for the faint hearted. For clarity and entertainment, once more, the Russian delegate: “But the perception of the world of the community would be that legalisation is fine and dandy […] I recall that cannabis is the most abused narcotic drug substance in the entire world. This makes it indispensable for us to exercise strong control over this drug”[6].

**Control as an end in itself**

So the international control system is not designed simply to assess the possible harm that consumption of substances could cause and make these unavailable to the general public. It does not even matter that members tasked by their countries to make decisions in the plenary meetings have no understanding of the psychoactive effect of the substance in question, and merely insist on cannabis being a narcotic. What really matters is that inclusion of any substance in the schedules allows governments and their dedicated agencies to exercise strong control over domestic affairs and populations.
It is the controls over citizens and immigrants, with its multiple, deep-reaching powers from extracting the bodily fluids of drug-tested employees to credits and debits in the bank accounts of a suspect, that draws authoritarian governments to the drugs field. Control, random searches, easy arrests, mass incarcerations and in a handful of states, workloads for their sword or syringe wielding executioners.

This no longer hidden agenda has been riding on the back of an international Convention that is ostensibly dedicated to the “welfare of mankind” for over half a century. It has been the greatest gift to authoritarian regimes, criminal justice institutions and criminal organisations alike. As research data from North America, Europe and Israel is showing with ever greater clarity, what was once called an aberrant “drug seeking” behaviour could be seen as the natural and instinctive quest for well-being.

Instead of using the potential of international cooperation to explore the full benefits, medical, industrial, etc. of the three iconic plants, the efforts of the control system have been dedicated entirely to, well, the benefits of the control system. Both terms are relevant here. Governmental authorities appropriate with gusto the powers “to control”, while “the system” comprises all the officials and the legion of experts (authors included) who chew on the fat of the wider drugs discourse.

**What is a drug?**

Herein lies the central problem, that obscurity and misunderstanding around the core problem that system has been erected to correct – the “world drug problem”. Because the understanding of drug does not only vary dramatically between Saudi and Iran, where alcohol is demonised on the one hand, and the European consumer societies on the other. It is a question nobody wants to raise, but closer scrutiny shows that this is precisely what delegates should be concerning themselves with. If a “drug” is, like the Russian delegates imply, “something that we can control”, or that allows the criminal justice agencies to “arrest and punish”, then the time has come for democratic states to break rank.

Scientific breakthroughs from discovering the endocannabinoid to understanding the reward pathways show humans as having an intimate relationship with plant based psychoactives. What has, perhaps, complicated this relationship is the amplification of potency through synthetisation, and the rate of trade and exchange in the course of what is commonly spoken of as globalisation – a process that was in effect something that could in part be attributed to “drug seeking behaviour”.

(Did Colombus not set out looking for spice and come back with tobacco?).

With the deconstruction of the category “drug”, the very reason for the system on which the CND is premised falls away. The delegates gather, after all, to discuss, and in their discussions, readily invoke, the “World Drug Problem”. Now there are global challenges that many people can recognise, global warming and climate change for instance. But where does one ever hear reference to the “World Drug Problem”? Only on the floor of a conference called together to discuss it.

So in summary, we have a system that is premised on a chimera, holding together state parties in an accord that its stronger members – and some brave smaller ones – are now in open breach of, and that serves mainly as a pretext for committing state sponsored violence against its citizenry. We have predicted in our book that it cannot last much longer. What the gathering in Vienna last month demonstrated all too clearly is that it does not deserve to either.

A number of countries have already broken ranks by legalising the production, distribution and use of cannabis. Others have lifted penalties on consumption and opened the provision of medical cannabis. In Germany, for instance, an estimated 40,000 – 60,000 patients received medical cannabis in 2018. The majority will have their expenses reimbursed by their medical insurance. In the UK progress has been somewhat slower, with a handful of patients actually receiving medical cannabis owing to tremendous regulatory obstacles. Yet demand from patients and recreational consumers is exerting moral pressure that combined with the financial firepower of “big cannabis” companies listed on either the TSX or the Canadian Securities Exchange will be difficult to resist.
We therefore foresee a series of defections of countries who will continue to be signatories but make reservations, the model first pioneered by Bolivia with regard to the coca leaf, on cannabis. As they follow Uruguay and Canada the actual provisions of the system will become meaningless and eventually fall into desuetude. Among authoritarian elements the treaties will live on, but Vienna gatherings will no longer have the grandeur and dignity that at present is one of the few redeeming features of an otherwise dismal system.

Notes
2. The term is borrowed from McCoy (2019).
4. Author Interview with Chief pharmacist and chief of national hospital laboratories, General Hospital, Niamey, October 1, 2018.
5. These problems have been raised in inter alia: Ernst Yorke et al. (2019), Klein (2019), HRW (2011).
6. See the CND blog for a record. It has to be added that this is not an official version, as neither INCB nor UNODC.

References

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Challenges to providing culturally sensitive drug interventions for black and Asian minority ethnic (BAME) groups within UK youth justice systems

Helen Gleeson, Karen Duke and Betsy Thom

Abstract

Purpose – The purpose of this paper is to explore how substance use practitioners intervene with ethnically and culturally diverse groups of young people in contact with the youth justice system.

Design/methodology/approach – Telephone, face-to-face interviews and a focus group were conducted. Data were analysed thematically using a frame-reflective theoretical approach.

Findings – Practitioners tended to offer individualised interventions to young people in place of culturally specific approaches partly due to a lack of knowledge, training or understanding of diverse cultural needs, and for practical and resource reasons.

Research limitations/implications – Practitioners reject the official narrative of BAME youth in the justice system as dangerous and in need of control, viewing them instead as vulnerable and in need of support, but report they lack experience, and sufficient resources, in delivering interventions to diverse groups.

Originality/value – There is little information regarding how practitioners respond to diversity in their daily practice. This paper is an exploration of how diversity is framed and responded to in the context of youth substance use and criminal justice.

Keywords UK, Intervention, Practitioners, Substance use, Youth justice, BAME

Paper type Research paper

Introduction

This paper reports on findings from a larger study exploring substance use interventions aimed at young people within the youth justice system and focusses on the views of practitioners working across these arenas in terms of the need for, and their ability to deliver, culturally specific interventions to black, Asian and minority ethnic (BAME) young people. The study presented here uses the framing approach as described by Rein and Schon (1993, 1994) and Van Hulst and Yanow (2016) to explore the frames applied by professionals working with diverse groups of young people through youth justice and substance use services and how these can be placed within the context of policy and practice frameworks. This paper focusses on the following research questions:

RQ1. How are young people from diverse ethnic backgrounds framed by practitioners working within drug interventions and the youth/criminal justice systems in the UK?

RQ2. How do practitioners respond to the needs of BAME young people using these services?

RQ3. What are the challenges identified by practitioners to engaging with, and supporting, BAME young people who use their services?
Background

In 2015–2016, 18 per cent of 16–24 year olds in England and Wales reported having used an illegal drug in the past year, a similar proportion to that of the previous seven years (HM Government, 2017). At the same time, the number of young people being prosecuted through the courts for drug offences has been steadily declining since 2007, with most being given supervision or community orders instead of custodial sentences (YJB, 2018). Most drug offences are detected through police stop and search which can result in immediate custody, a fine, caution, warning or a conditional “out of court” disposal order (Shiner et al., 2018). Out-of-court orders usually entail some form of police caution and mandatory attendance at a youth offending service (YOS) who provide substance use interventions alongside mental health support and education and training. The aim of the YOS intervention is to prevent further criminal behaviour and avoid custodial sanctions.

In the year to March 2017, 28 per cent of all arrests of 10–17 year olds, in the UK, were of individuals from BAME backgrounds (18 per cent of population) while 84 per cent of all arrests in this age group were male (51 per cent of population) (YJB, 2018). Recent reviews of the youth justice system suggest that young black males are nine times more likely to receive a custodial sentence for a drug offence when compared to white males in the same age group (Lammy, 2016; Shiner et al., 2018). This suggests a disproportionate number of BAME young people are not being offered community based sanctions that include substance use services through YOS teams, although in many cases, ethnicity is not accurately recorded (YJB, 2010).

Numerous reports have shown that there are ethnic disparities in how young people are processed through the youth justice system (e.g. Lammy, 2016; Shiner et al., 2018; YJB, 2010; 2018). This can create an aura of mistrust among young people from BAME backgrounds who are referred to services that are part of the justice system such as substance use interventions delivered by Youth Offending Teams[1] (YOTs). Previous investigations have indicated a lack of clear guidance or training on providing culturally appropriate substance use services within the youth justice system; however, the perceived need for culturally specific services amongst professionals and young people is mixed (YJB, 2010).

Research from the field of cultural psychology highlights the need to consider the influence of cultural traditions, social norms and beliefs on the drug using patterns of young people and any subsequent health impacts. This research cautions against assuming interventions developed for one minority group will be effective for other minority groups (Burlew et al., 2013). Other research reports that those from minority ethnic communities lack trust in the confidentiality of substance use services and perceive services to be lacking in cultural competence (e.g. Fountain, 2009; Gray and Ralphs, 2019). Overall, the literature suggests the need for culturally sensitive staff who can adapt to the needs of the individual young person whilst also understanding the potential influences of cultural factors that may impact on engagement, effectiveness and outcomes.

When asked about preferences for drug education and intervention programmes, some BAME individuals favour those delivered by people from their own communities with experience of problematic drug use (Beddoes et al., 2010). Previous UK Government strategies have noted a need to ensure diversity amongst the workforce in drug interventions to help encourage greater engagement in services across ethnicities and cultures. However, it is not possible to determine the ethnic or cultural background of those working in youth justice substance use services from currently available workforce data (Ministry of Justice, 2017). A study by the Youth Justice Board, which included interviews with 93 BAME young people involved in the justice system, found that there was no preference for ethnically matched key workers among young people and just 22 per cent thought having others of their own ethnicity was important in group-based interventions (YJB, 2010).

Within the research on BAME adult use of substance use services, perceptions of a lack of cultural diversity and sensitivity among service providers is seen to act as a barrier to help-seeking (see Fountain, 2009). While also citing cultural stigma as a further barrier, this research found that many from BAME communities find services difficult to engage with individually and have a desire for more family involvement in their treatment, an approach which was not usually made available to them (Fountain, 2009; Fernandez, 2015). This research does not differentiate between older
and younger generations however, and it is not clear if, or by how much, young people’s preferences for substance use intervention differ from those of adults.

Literature from the USA has called for cultural variables to be considered as part of the young person’s life experience when determining how to approach prevention or treatment of substance use (Castro and Alarcon, 2002; Steinka-Fry et al., 2017). However, the focus within this literature tends to be on standard models, or programmes, of treatment (e.g. Cognitive Behavioural Therapy) and lean towards treatment for those with addiction problems. In the UK, YOT-delivered substance use interventions tend to have a more generalised wellbeing, harm-reduction approach as young people present with multiple additional social problems that need to be addressed (authors anonymised for peer review; Duke et al., under review; Thom et al., 2018) making comparisons in outcomes between the two countries difficult.

Much of the adult literature and the US literature cited above primarily report on outcomes for those in the voluntary treatment sector. Compulsory, or coercive, treatment as experienced by young people referred through the youth justice system may lead to problematic engagement of young people in the service, lower commitment to reducing or stopping substance use and issues of trust between the young person and practitioner.

Within the voluntary substance use treatment sector, it has long been acknowledged that BAME individuals are under-represented compared to their white counterparts in both young people and adult services (Fountain, 2009). While there are some good practice examples of these approaches within the voluntary adult sector (e.g. Fernandez, 2015), there is little UK based research that focuses on young people within compulsory substance use services or from within the youth justice system. What is available is of varying methodological quality and the literature is inconsistent in its use of definitions of ethnic groups and drugs included (Beddoes et al., 2010). At present, we still know little about the importance of considering cultural factors in delivering substance use interventions to young people who are referred to services through police-, or court-, ordered directives or how professionals in these services meet the needs of young people from ethnically and culturally diverse backgrounds.

Theoretical framework

Van Hulst and Yanow describe framing as “[…] the interactive, intersubjective processes through which frames are constructed” (2016, p. 93). Frames are similar to cognitive schemas (as described in the psychological literature) that influence the ways we process and understand social, political and policy relevant information. Rein and Schon (1993) propose three processes involved in the construction of frames: naming, selecting and storytelling. Policy actors use naming to focus on aspects of a situation/problem that is reflective of their own understanding (e.g. “vulnerable” young people; “criminal” drug users) and which allows them to select only these features and draw attention away from other aspects creating a story that is coherent and understandable.

Van Hulst and Yanow (2016) see framing as a means of sense making of problems, situations, or contested issues that occur when individuals engage in a conversation with them. They add to Schon and Rein’s framework of framing/frame making by including two further concepts; sense making and categorising. Sense making is described as the evaluation of a situation/problem in the context of prior or existing knowledge or training, and the determination of what future action to take which can also be influenced by personal and professional backgrounds, whilst categorising occurs in conjunction with naming and selecting to identify important information and/or discard that which is thought to be irrelevant.

They expand on the storytelling aspect of Rein and Schon’s framework by describing the ways that each of the individual elements of framing are woven together through a “narrative frame” that “[…] frame their subjects as they narrate them, explicitly naming their features, selecting and perhaps categorizing them as well, explaining to an audience what has been going on, what is going on, and, often, what needs to be done – past, present, and future corresponding to the plot line of a policy story” (p. 100).
Such frames that may be applied by practitioners can be constructed by the individuals or institutions themselves but may also be those imposed through policy or practice requirements that are subsequently absorbed by practitioners or adapted to meet the needs of particular service user groups.

Data and methods

The results reported in this paper come from 19 individual interviews and one focus group \((n = 6)\) with professionals who work with young people through the youth justice system and substance use interventions. The individual interviews were conducted face to face \((n = 5)\) or by telephone \((n = 14)\), and the focus group was conducted for ease of scheduling within the service setting by request of the service manager. An earlier scoping of current interventions aimed at reducing or preventing substance use in young people within the youth justice system revealed a lack of targeted interventions aimed at this group (Thom et al., 2018). The services identified through this scoping work were all invited to take part in the research study and interviewees self-selected through this invitation. The interviews aimed to gain a broader understanding of: the types of interventions currently being offered to young people; the causes and wider contexts at play as perceived by professionals in bringing this group into the interventions; the frameworks or approaches thought to be most useful and; the challenges experienced by professionals in engaging young people and working within these systems.

Interviews lasted between 40 min and 1 h, with the focus group lasting 1.5 h. All were recorded and later transcribed for analysis. Interviewees were employed within youth work, youth justice, substance use services and commissioning, and were based across the UK including, London, the South East, Midlands of England and Scotland. Ethical approval for this study was granted by Middlesex University Health and Social Care research ethics committee.

Early in the data analysis process, it became apparent that diversity (including ethnicity, culture, religion, sex and gender) among service users was an important theme that would benefit from further investigation alongside analysis of the interventions themselves. Therefore, the focus of this paper is on issues of delivering appropriate drug interventions to an ethnically and culturally diverse population of young people within the criminal justice system and the challenges experienced by professionals in aiming to achieve this. As we had not intended to focus on issues of diversity initially, this demographic information relating to the professionals interviewed was not collected.

Findings

Whether diversity was considered a major factor that affected interventions or ways of working with interviewees or not was related to the geographical area in which the practitioner was based. Reflecting the population in London, these services had a more diverse service user base compared to those in the midlands or Scotland which have predominately white populations. This impacted on their levels of experience with BAME young people and how they adapted services to meet different cultural needs. The diversity of service users that practitioners had experience of working with included established populations in the UK such as Black Caribbeans, more recent migrant populations including Eastern Europeans, Romany Gypsies and religious minorities (e.g. Muslim).

Similar to findings reported by the YJB (2010), there was acknowledgement of differences amongst ethnic groups in terms of the substances most commonly used, patterns of use and a need for more culturally sensitive training. Some practitioners, whose service users were primarily white and working class, focussed more on the impacts of social and economic disadvantage experienced by young people they worked with and felt that this was of more immediate concern in impacting on the interventions they provided. While practitioners identified diversity as an important issue of concern within their services, not all services had the same experiences which were influenced by their local demographic profiles.
Framing current and emerging needs of diverse groups

Practitioners were aware of the diversity of young people living in the areas they worked in, but did not see this reflected in the demographic profile of young people being referred to them through the youth justice system. Attempts at sense making, in the ways described by Van Hulst and Yanow (2016), raised questions about both the services themselves and the systems within which practitioners worked, but did not lead to identified future actions:

[...] it’s still predominantly white males that we do see within our service and is that a case of because that’s how our services are made, that’s how we’re tailor made to work with that group, subconsciously we have perhaps an unconscious bias that we’re not aware of, or is it because that’s just what comes through the system? (Regional manager, commissioned provider)

Selecting and categorising cultural beliefs to create an understanding of the differing needs of diverse young people was also evident in the way that some professionals identified influences on young people’s use of substances. The narratives constructed by practitioners around the specific needs of culturally diverse young people referred to the different types of substances used (or expected to be used) by different groups rather than differences in approaches likely to be needed or broader influences of culture or ethnicity:

We do seem to be getting a lot more younger people coming through now [...] celebrating the fact that they’re completely abstinent from alcohol, but [...] within the young person’s population, it’s probably 45/55% BAME community. So obviously that will have an impact because they come from South Asian communities, so their culture will be that they don’t drink. (Service manager, commissioned provider)

Both storytelling (through explaining why some groups are likely to present to services in the future) and sense making (through predicting future needs) were evident here:

I think steroids is going to increase, particularly again BAME communities, a lot of young Asian males being quite petite and slim using steroids to build them up and what goes with that is the cocaine use as they get older [...] I think image enhancing stuff coming through is a bit of a concern for me. (Service manager, commissioned provider)

Professionals reported that future provision of services may need to adapt to appropriately support young people from the diverse cultural and ethnic backgrounds in their own localities. However, none of those interviewed reported putting in place culturally specific approaches or interventions that would meet these needs when required. In van Hulst and Yanow’s framework, they were not engaging in “sense-making” by using their understanding of these needs to create future actions or plans.

Responding to diverse service user’s needs

The need for flexible approaches to working with diverse young people was highlighted across services and practitioners and was framed by some through a narrative of both vulnerability of young people accessing services and their presenting complex needs. Depending on the local population, some services categorised young people’s needs not only by their ethnic diversity, but also by additional diversity factors including gender, poverty and educational needs:

When you put in kind of all the diversity factors, which is not just gender and ethnicity but whether they are looked after [i.e. in the care system], what their backgrounds have been, when you take special educational needs, all that lot, any material that is just inflexible just won’t work now. (Focus group, YOT manager)

Within the focus group, there was much discussion around these common issues experienced by young people that the team worked with. They spoke at length about the need to have access to a range of materials available that could be adapted easily. For this team, it was important to be able to provide support to the diverse range of young people who were referred to the service without having to construct new interventions each time.

Other services had begun to work in collaboration with outside organisations as a way of trying to meet the needs of young people of different faiths and of ensuring that services were communicating in ways that they were familiar with:

What we’ve also done is [...] we work with [...] the Islamic College for Imans and we brought the Imans in. These were young people from probably about the age of 17, 16, 19 and we re-wrote foundations of recovery with Islamic faith slants. (Service manager, commissioned provider)
For others, it was not always obvious that their interventions could be inappropriate for some service users but they were keen to express a willingness to consider how some interventions may benefit from being adapted; in some cases, this could lead to a re-framing of young people’s needs and a greater awareness of the multitude of ways that culture can affect how services are experienced:

So, for example […] we’ve had an away-day today and I think I’ve got about 20%/30% of my staff are from BAME communities and when we were there we did what we call a […] Gong Blast, so it’s music […] obviously music in some faiths is not as accepted as it is in within other faiths and I hadn’t even thought about it […] I think those are some of the cultural issues that we need to be considering when we’re delivering interventions, particularly if we’re using some of the dramatic art stuff as well as expression. (Service manager, commissioned provider)

For most services, however, they were still contending with materials and intervention approaches that some viewed as outdated and unresponsive to the diverse needs of young people they work with. This suggests that while professionals may be open to changing their frames, or categorisations, of young people, the act of storytelling becomes frustrated when they are bound by the limitations of what is available to them to engage with diverse groups:

[…] whoever the young person is in your head that you are thinking of, that person doesn’t really exist. Like to us every child is so different […] If you look at the census for [place] there’s like 100 different ethnicities and […] languages […] So, something that only works for a white group is pointless to us and you know it’s not right is it? The world has moved on, but so much of stuff is still based around that. (Focus Group, youth worker)

In reality, the most common response to the diverse needs of service users among practitioners was to provide “bespoke”, individual interventions depending on what they viewed as being needed by that young person.

A lack of experience with and knowledge of the needs of diverse groups of young people as expressed by many of the participants influenced their ability to make sense of the support needs of these groups. When combined with the categorisation of service users as a primarily vulnerable group of young people, this led to the selection of individualised, or bespoke, approaches to intervention for each young person they worked with.

Challenges within practice

Reductions in funding, staff and other resources are common issues raised across public services in the UK, and some of our interviewees talked about how they can impact directly on a service’s ability to offer interventions to a diverse client base:

In terms of the materials we use, how do you have a bank of materials that are okay for a white lad from [local area], as well as someone who has got Roma heritage, someone who has got Caribbean heritage, someone who has only just come here from Somalia. You know we get all these lads, different lads and we can’t afford to buy interventions for every single group […].

(Focus group, YOT manager)

The process of sense making of diverse young people’s needs, and how they can be difficult to incorporate into practice was evident when professionals also spoke of reduced workforces for their services and how this can leave them with limited experience and knowledge of cultural diversity amongst staff. Issues of engagement of young people within the frame of their cultural backgrounds were also raised, where there was a sense that family attitudes can influence how a young person works with the service:

[…] a couple of years ago, we had […] only small numbers, but quite an influx of lads that we think were Roma heritage […] But at that point that was kind of “how are we going to connect with these lads really?”, because they really are outside of the education system and you have got multi-intergenerational views on particular topics and things like that. I don’t know how that plays out in terms of substance misuse […]. (Focus group, YOT case worker)

A further challenge discussed by some practitioners was being constrained to working with those who are referred to them when they have no control over this part of the process. This can lead to an undermining of relevant knowledge and hampers attempts to
engage with diverse communities on a voluntary basis as well as those referred through youth justice services:

But we do struggle with BAME referrals. That’s an area that we are always trying to work on and how we can engage better with the BAME community […] I think they are areas that we could develop into, but it’s a bit of an unknown what is going on in those communities, because we’re not really getting referrals from them. (Team leader, commissioned provider)

Other narratives focussed on the young people’s attitudes towards criminal justice and how they framed their interactions with services they view as being aligned to institutions they had little trust in. This could be a particular challenge when working with BAME young people who are more likely to have had negative experiences with the justice system compared to white youth (Lammy, 2016; Shiner et al., 2018). This issue of trying to counteract young people’s own categorisation of youth/substance use workers was raised as a challenge by some practitioners who felt they needed to convince the young person to re-frame their perspectives on substance use services and was a source of frustration for many:

[...] obviously they are already wary of criminal justice, so sometimes they assume that we’re working in collaboration with the police, or you know like drug enforcement agencies. They can sometimes be quite subdued and wary about the workers and the information that they’re actually telling us. So sometimes it takes a little bit of, like a lot more skill to actually extract a truthful and honest, candid engagement with them. (Substance use worker, commissioned provider)

While most practitioners stated that they had received no training in cultural diversity, instead focussing on being able to adapt to individual needs, those who had talked about the benefits of having different perspectives on the experiences of the young people they work with. One spoke of attending training that gave him insight into the emotional conflict that can occur in young people of mixed race who may feel they are being forced to identify with one culture or the other. While this would not directly impact on how a service is offered, it provided a means to understand the frames within which a young person was trying to navigate their lives and could potentially help to inform ways of engaging with them. Training such as this, however, was sparse across the services that interviewees came from despite many stating a desire to access it.

Discussion

Since 1995, UK drug strategies have tended to frame drug use as a criminal, rather than a public health, concern (Duke, 2006; Monaghan, 2012), which can be seen in the series of strategies produced by successive governments up to the present. These strategies have created a government stance that equates higher crime rates with certain “problematic” groups in society who need to be targeted to reduce their drug using (and thereby criminal) behaviour (Monaghan, 2012). As such, it is not unusual for a young person to receive a court order that requires them to attend substance use treatment as part of their sentence to be spent in the community.

Previous literature has shown that those from diverse ethnic and religious backgrounds respond best to tailored and culturally sensitive substance use prevention and intervention approaches (Burlew et al., 2013; Steinka-Fry et al., 2017). Policy and guidance on providing such services do not acknowledge these differences nor do they require services to respond to the cultural needs of their service users. The limited research that is available that directly asks young people of BAME backgrounds for their views has found that they have no desire to be culturally or ethnically matched to case workers and they view the ability of case workers to build a trusting relationship with them as most important in helping them to reduce drug use and future offending (YuB, 2010).

As found by Castro and Alarcon (2002), practitioners in this study adapted available interventions to meet the needs of their diverse service users but had no way of knowing if these adaptations were the most appropriate or if they increased or reduced the likelihood of positive outcomes. Ethnic minorities are not homogenous; coupled with a lack of reliable and valid data available in the UK on substance use across ethnicities, it is inherently difficult to develop tailored support packages for such diverse young people (Wanigaratne et al., 2003). As mentioned by some of our
participants, across drug treatment services there are “new” ethnic minority populations such as Eastern Europeans who are now presenting more frequently to services that are not prepared to meet their needs for culturally appropriate treatment approaches (Fernandez, 2015). Some practitioners also perceived family norms to impede engagement of young people, perhaps inadvertently using cultural stereotypes to explain why they struggle to effectively intervene with some minority groups.

Van Hulst and Yanow (2016) argue that individuals can become so aligned to their frames, or those that they are comfortable and familiar with, that frames become part of that individual’s identity which means the process of re-framing becomes difficult and emotionally charged, where identities are “enmeshed in the sides they have taken in intense policy controversies” (p. 105). Professionals in this study reported multiple views on what diversity means within their own service contexts (including gender, religion and economic disadvantage) which influenced their categorising and sense making of the needs of young people from diverse backgrounds. When facing challenging budget restraints in addition to a lack of training in cultural differences, services are struggling to both understand how to respond to BAME young people and develop interventions that are likely to be effective.

A lack of trust between BAME communities and the police and criminal justice system has long been recognised and could impact on willingness and motivation to engage with intervention services that are perceived to be part of this system (Amnesty International, 2018; Lammy, 2016). While many of the practitioners we spoke to are aware of this and make efforts to separate themselves from the justice system, best practice guidance on how to address this issue is not available, neither is an official recognition that this is likely to be a barrier to full engagement of young people in substance use or other wellbeing services. In response, the practitioners in this study concentrated on offering individualised interventions to all young people as a means of meeting support needs and of creating their own “frames” of service users that do not always match with an official, policy discourse.

Conclusion

Both the UK Drugs Strategy (HM Government, 2017) and the Serious Violence Strategy (HM Government, 2018) make explicit links between violent crime and drugs, reinforcing the narrative of young black males as dangerous and their drug use and/or criminal involvement as inevitably gang related. Preventing or reducing drug use is itself often framed as a means of protecting the safety of society, and amongst younger people, of protecting the safety of “vulnerable” youth. If the accepted narrative of non-white substance using youth is that of the dangerous, risky gang member, it is unlikely that interventions to reduce the individual harm of substance use will be tackled with empathy or with genuine reference to the needs of this population. This is evident in substance use services that are accessed through the youth justice system where guidance on culturally and ethnically appropriate approaches is not offered despite the awareness of such a need amongst practitioners.

While some prominent individuals have raised the disparities in stop and search, arrests and custodial sentencing of BAME young people (e.g. Lammy, 2016; Amnesty International, 2018) other minority groups are frequently ignored in such debates. Practitioners working across the bounds of youth justice and substance use are themselves aware of the changing demographics of the young people accessing their services but are not currently offering culturally sensitive or adapted interventions. At present, the best they can do is to continue to offer “flexible” interventions that attempt to offer individual services without adequate training or awareness of the differential impact of cultural nuances that would make interventions most likely to be successful for different ethnic groups.

Note

1. Youth Offending Teams (YOTs) work with young people when they encounter the youth justice system, and they are overseen by local councils and work in collaboration with the police, courts, social services and schools. They provide intervention with the aim of preventing further involvement in crime within the community.
References


Further reading


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Critical reflections on quality standards within drug demand reduction

Niels Graf and Heino Stöver

Abstract

Purpose – The purpose of this paper is to critically reflect on the usefulness of quality standards aimed at prevention interventions for drug using young offenders.

Design/methodology/approach – This paper uses critical literature on quality standards, readings of quality standards and qualitative interviews as well as focus-group discussions with professionals working in services targeting drug use among young offenders.

Findings – The findings show discrepancies between the idea that quality standards provide a tool for supporting the implementation of more effective interventions and professionals’ experiences with quality standards as almost absent in their work.

Originality/value – This viewpoint highlights barriers to the implementation of quality standards that have to be overcome if quality standards are to be adopted and implemented in practice.

Keywords Quality standards, Young offenders, Drug use, Prison health, Barriers to implementation, Criminal justice systems

Paper type Viewpoint

Introduction

It is hard to imagine any social, political and economic field that is not permeated by quality standards (Timmermans and Epstein, 2010). In fact, Brunnsson and Jacobsson’s (2000) diagnosis that today’s world is a “world of standards” certainly also applies to drug demand reduction. National bodies, as for example, the UK National Institute for Health and Care Excellence or the German Society for Addiction Research and Addiction Therapy, and international organizations, such as the World Health Organization (WHO), the United Nations Office on Drugs and Crime (UNODC), the European Monitoring Centre for Drug and Drug Addiction (EMCDDA) or the European Union (EU), have elaborated a whole range of guidelines and quality standards concerning several facets of drug prevention and treatment among various target groups. The International Standards on Drug Use Prevention (UNODC, 2015), the International Standards for the Treatment of Drug Use Disorders (UNODC, 2017), the Minimum Quality Standards in Drug Demand Reduction (Council, 2015) or the European Drug Prevention Quality Standards (EDPQS) (EMCDDA, 2011) are just some examples of this steadily growing body of quality standards on drug demand reduction. The purpose of these standards is to help ensure the design and delivery of effective drug demand reduction interventions and to maximize the impact of these interventions (UNODC, 2012; Ferri et al., 2018) by bridging “the gap between science and practice” (Council, 2017, action 10).

The consequences and effects of quality standards are, however, mostly unknown as there is little empirical analysis of their implementation and outcomes (Timmermans and Epstein, 2010; Arnold, 2017, p. 21).

Based on research done within the EU funded project “Exchanging prevention practices on polydrug use among youth in criminal justice systems (EPPIC)”[1], this viewpoint will critically reflect on the barriers that exist for implementing quality standards in institutional settings and argue that quality standards have little influence on everyday intervention practices.
In order to do so, we first give an overview of common characteristics of quality standards. These characteristics define what quality standards are but also have implications for their possible implementation in institutional settings. On the basis of the results from interviews and focus-group discussions with professionals working in interventions aiming at drug use among young offenders in Germany, as well as on critical literature on quality standards, we then present barriers to the implementation of such standards. Finally, it is briefly discussed how these barriers could be tackled and what this means for the design of quality standards.

Quality standards: aims and defining characteristics

Due to the omnipresence of quality standards in social, political and economic life the term “quality standard” is used in a wide variety of domains. More often than not the term is not explicitly defined, but used together with, or instead of, terms like “good practice,” “evidence-based practices” or “guidelines” (cf. Star and Lampland, 2009).

There are, however, particular characteristics that most quality standards have in common (Brunsson et al., 2012; Timmermans and Epstein, 2010). First, quality standards can be characterised as a distinct type of formulated rules. Quality standards explicitly stipulate what ought to be done in order to ensure “quality.” Second, quality standards are voluntary for potential adopters as standard-setting bodies typically cannot directly enforce quality standards, but only recommend them for implementation. Thus, quality standards can be considered as a type of advice (Brunsson and Jacobsson, 2000, pp. 12-13). The regulative capacity of standards, therefore, depends on the actions of potential adopters which commonly only comply with quality standards if they perceive standards to be legitimate and relevant (cf. Bernstein and Cashore, 2007; Seidl, 2007). Third, most quality standards are meant for broader use by all relevant actors in a specific domain (Rasche, 2010). They are intended to be “rules that many use” (Kerwer, 2005, p. 611) because quality standards can only exert regulative power if they are applied by a wide range of actors in a given domain. If, for example, quality standards on drug demand reduction are only applied by a minority of relevant actors, the “quality” of drug demand reduction in general obviously does not change a lot.

Taken together, general characteristics of quality standards are that they aim to ensure “quality” in a specific domain by formulating rules typically based on acknowledged ethical principles as well as scientific evidence and expertise (Furusten, 2000). The standards are promoted by standard-setting bodies as, for example, the UN or the EU through guidelines and tools that are at best easily accessible and relevant to a wide audience of actors (cf. Ferri et al., 2018).

“Quality,” however, is mostly only vaguely defined in existing standards. To give an example, the EDPOS state that prevention activities are of high quality if they are relevant, ethical, evidence based, evidence providing, (cost)effective, feasible and sustainable (The European Prevention Standards Partnership, 2015) instead of giving an exact definition of “quality.” While this may prompt the question of how quality standards can work when it is vaguely defined what quality actually is, the main rationale for providing and promoting quality standards in drug demand reduction is the assumption that such standards will produce more impactful interventions in terms of effective outcomes (UNODC, 2012; The European Prevention Standards Partnership, 2015; Autrique et al., 2016). It is against this background that the EU also argues that quality standards could “bridge the gap between science and practice” and act as a powerful tool for implementing more cost-efficient and effective services[2].

With regard to the practice level, most quality standards, including quality standards on drug demand reduction, are explicitly directed at front-line professionals and commissioners, funders or policy makers at the same time (e. g. EMCDDA, 2011; UNODC, 2012, 2017). Therefore, quality standards necessarily have to be somewhat vague since they have to meet quite contradictory demands.

Yet, quality standards may also easily fail to accomplish these different demands (cf. Brunsson et al., 2012; Timmermans and Epstein, 2010). Clinical and health research, for example, shows that most standards and guidelines in the health care field fail to be implemented into practice and policy and, therefore, have little effect on actual clinical practices unless they are accompanied by
rather extensive translation efforts that take into account specific settings and provide educational guidance on how to use and implement standards and guidelines (Grimshaw et al., 2001; McGlynn et al., 2003; Aarons et al., 2011; Grimshaw et al., 2012). By referring to the perspectives of professionals working in interventions targeting drug use among young offenders in the next section, we will argue that similar difficulties are present for the use and implementation of quality standards on drug demand reduction.

Quality standards relevant to drug use among young offenders

There exist only a few quality standards potentially relevant to drug use among young offenders. These standards were identified through a systematic literature review, a grey literature search and an expert consultation (see Table I) and were related to juvenile justice and delinquency; imprisonment in general; health promotion in criminal justice systems; and prevention, treatment and/or harm reduction related to (adolescent) drug use (see Table I). With the exception of a standard from the UK, there is as yet no national or international quality standard explicitly devoted to drug use among young offenders.

We analysed these collected quality standards in terms of an approach to content analysis proposed by Mayring (2002) to identify the most common and important principles promoted in these standards. Principles highlighted in most quality standards include, for example, that interventions should be "evidence-based," "tailored to the needs of clients," constantly "evaluated" or that, in the case of young inmates, "continuity of care" should be secured. Following from this, seven professionals were interviewed about their perceptions of quality standards in general and the principles identified by the content analysis in particular. We did the same in a focus-group discussion with five participants. Within the interviews as well as the focus-group discussion, we asked, for example, what quality in drug demand reduction actually means to them, if and in which ways they build their work on quality standards and/or experiences of good practice, or which principles of quality standards they perceive as (un)helpful to their professional endeavors. All interviews as well as the focus-group discussion were deliberately conducted with professionals working in different interventions targeting drug demand reduction among young offenders as this group of professionals typically designs and implements specific interventions[3].

Barriers to implementing quality standards

The discussions of quality standards with professionals revealed, perhaps not surprisingly given the nature of quality standards and experiences of their (non-)implementation in other health care fields, several barriers to implementation of quality standards on a service-delivery level.

| Table I Examples of quality standards potentially relevant to drug use among young offenders |
|-----------------------------------------------|------------------|------|
| Quality standards                            | Standard-setting body | Year |
| Examples of quality standards concerning juvenile justice and delinquency | UN Guidelines for Action on Children in the Criminal Justice System (Vienna Guidelines) | UN | 1997 |
| Examples of quality standards concerning imprisonment | Recommendation on the European Prison Rules | Council of Europe | 2006 |
|                                                  | UN Standard Minimum Rules for the Treatment of Prisoners | UN | 2015 |
| Examples of quality standards concerning health promotion in criminal justice systems | The Madrid Recommendation: Health protection in prisons as an essential part of public health | WHO Regional Office for Europe | 2010 |
|                                                  | Strasbourg Conclusions on Prisons and Health | WHO Regional Office for Europe/Council of Europe | 2014 |
| Examples of quality standards concerning drug demand reduction | European Drug Prevention Quality Standards | EMCDDA | 2011 |
|                                                  | International Standards on Drug Use Prevention | UNODC | 2015 |
The first, and perhaps most basic, barrier to implementation of quality standards on drug demand reduction emphasized by the interviewed professionals, is that existing quality standards are quite inaccessible to them. In fact, most of those interviewed were unaware of existing quality standards. This inaccessibility is compounded by the fact that most quality standards are quite extensive. The main document of the EDPQS, for example, contains about 290 pages. The TREATNET Quality Standards for Drug Dependence Treatment and Care Services (UNODC, 2012) represents an example of shorter quality standards, but still encompasses nearly 100 pages. In addition, quality standards on drug demand reduction often use a quite specialized technical language in that these documents, for example, talk about “baseline data” or “follow-up measurements” concerning the evaluation of interventions. The professionals, consequently, found it difficult to understand the principles promoted by quality standards that we presented to them. Moreover, most quality standards are exclusively available in English and only sometimes in other languages. One of the very few exceptions is the quick guide to the EDPQS which is now available in about 15 languages[4]. These barriers emphasised by the professionals in our study most likely also apply to many professionals in other countries.

The second barrier that came up in the discussion with professionals was difficulty to grasp the rather vague nature of the principles formulated in quality standards on drug demand reduction. In our discussions, this came out as frustrating, since they then had to “translate” these vague principles to render them directly applicable to their own specific interventions. While professionals aim at doing what is best for their clients and therefore actually agree with some of the principles promoted in quality standards, as for example the principle that interventions should be “tailored to individual needs,” they still needed information about how to practically implement them. The professionals were certainly keen to meet the needs of clients, but nearly all interviewees wondered how to do this in practice. In this regard, the EDPQS, for example, recommends conducting a needs assessment at the very beginning of every intervention, but gives little advice to professionals on how to implement a needs assessment (EMCDDA, 2011). Another example could be the widely promoted principle of providing “culturally sensitive” interventions (e.g. UN, 2004; UNODC, 2016). The concept of “culturally sensitive” interventions, however, is quite complex and it is, hence, widely debated which of the various culturally sensitive frameworks, dimensions or group specific themes are most relevant in drug demand reduction for racial/ethnic minority members (Steinka-Fry et al., 2017). Again, it is not sufficient that professionals know that “culturally sensitive” interventions are important. Rather, the concept needs to be backed up by concrete suggestions about what such interventions could look like in order to become a practically meaningful concept.

Moreover, the interviewed professionals did not necessarily share the same understanding of principles promoted in quality standards and, consequently, had different ideas about the implementation of these principles. Therefore, principles of quality standards may be implemented quite differently in practice and not necessarily in ways that standard-setting bodies intended (cf. Ismail and de Viggiani, 2018).

The third barrier identified, and the last we will discuss here, is that the policy environments in which interventions operate are not conducive to implementing quality standards on the service-delivery level. Especially since drug use among young people in touch with the criminal justice system cuts across different domains, namely criminal justice, health, welfare and substance use services, professionals emphasised that they have to struggle with several systemic factors if they want their work to be effective, and that the issues can hardly be tackled by single interventions. A good example of such systemic issues is the principle of “continuity of care,” i.e. continued access to prevention, diagnosis, treatment and care from the very first contact with the criminal justice system to a point after release from prison (WHO Regional office for Europe, 2010; Pont et al., 2018). This principle is promoted by most standards on prison health, but requires substantial coordination and communication efforts between different institutions and services like, for example, social welfare officers, health assurance officers, social workers and prison officers to become a living principle (cf. Public Health England, 2018). Yet, according to the professionals interviewed, it is clear that even those young people who successfully participated in an intervention after their release from prison oftentimes end up in homeless shelters without any further care. With regard to this problem, the professionals emphasised that it is difficult to engage all relevant actors and coordinate them on time in order to put this principle into practice. Similar coordination challenges in drug demand
reduction are likely to occur in every setting which requires the cooperation of different services like, for example, in the case of drug using parents (Grella et al., 2006).

Furthermore, professionals emphasise that they have to deal with scarce resources. Consequently, they simply do not know how to implement sometimes quite demanding quality standards. For example, many practitioners are interested in the principle of evaluation of interventions to be able to assess the effectiveness of their interventions, but either do not have the resources to assign external agencies to do the work or do not have the time and knowledge to do it on their own. In this vein, it is widely acknowledged that considerable training is an essential prerequisite for implementing quality standards (Ferri et al., 2018; Autrique et al., 2016).

The barriers presented here were the most important barriers that came up in discussing quality standards with professionals. While there still may be other relevant barriers, these barriers exemplify several challenges in implementing quality standards in institutional practices. Taken together, the barriers discussed here demonstrate that while most professionals are interested in the “quality” of their work and the intervention they represent, quality standards themselves are not necessarily useful to professionals on a service-delivery level.

What role for quality standards in drug demand reduction?

Given these barriers, it is highly questionable that existing quality standards are, or will be, widely implemented in services aiming at drug demand reduction since quality standards, as shown above, have to be perceived as relevant and legitimate by relevant actors to be adopted and implemented in practice.

To render quality standards more relevant to professionals, first, policy environments have to become supportive to implementing standards in practice. This especially requires policymakers to secure good cooperation and communication between different institutions due to the importance of systemic factors in preventing and treating drug use. It is obviously not sufficient only to elaborate quality standards; standard-setting bodies and national institutions have to provide sufficient resources to support services and professionals in implementing quality standards. This not only includes the provision of sufficient training opportunities, but also professionals have to be equipped with enough funds and, importantly, time to enable them, for example, to conduct evaluations or needs assessments. The provision of sufficient resources, however, relies on the political will and opportunities of policymakers probably not given in all cases. Second, the nature of quality standards themselves needs to be changed. Quality standards have to be designed in a way that is easily accessible for professionals. Therefore, quality standard documents need to be provided in national languages and should reflect different cultural contexts so that all professionals can easily understand their contents. Moreover, instead of just presenting rather abstract principles, quality standards have to provide detailed and concrete steps for the translation of these principles into practice. While this is certainly a high demand on standard-setting bodies, the challenge remains that the promoted principles may otherwise just be too vague to be meaningful to professionals on the ground. Hence, standard-setting bodies and national institutions have to create better conditions if they want professionals to implement quality standards into practice and services. Without such changes, quality standards are likely to be perceived as only “empty” words by professionals on the service-delivery level rather than acting as a bridge between science and practice as envisioned by standard-setting bodies.

Notes

1. The project 768162/EPPIC, which has received funding from the European Union’s Health Programme (2014–2020). The content of this editorial represents the views of the authors only and is their sole responsibility; it cannot be considered to reflect the views of the European Commission and/or the Consumers, Health, Agriculture and Food Executive Agency or any other body of the European Union. The European Commission and the Agency do not accept any responsibility for use that may be made of the information it contains. See also www.eppic-project.eu

2. See, for example, the European drug prevention quality standards’ website: http://prevention-standards.eu/standards/ (accessed December 4, 2018).
3. All interviews as well the focus-group discussion were recorded, transcribed and then systematically encoded and analysed, and evaluated according to Mayring, in terms of content analysis. All interviewees provided written informed consent. The audio files were deleted after transcription and all identifiers were removed from the transcripts for data protection reasons.


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Let’s talk about chemsex and pleasure: the missing link in chemsex services

Jorge Flores-Aranda, Mathieu Goyette, Valérie Aubut, Maxime Blanchette and Frédérick Pronovost

Abstract
Purpose – The purpose of this paper is to document the experience of current and former methamphetamine users on their crystal meth use patterns and on their use of services related to their chemsex practice.
Design/methodology/approach – For qualitative component, two focus groups were formed with nine current users of methamphetamine and eight former users. Thematic analysis was performed to know their experiences.
Findings – All participants were already engaging in chemsex with various substances before they first started using methamphetamine. Methamphetamine use led some to slam (methamphetamine or mephedrone injection). Some participants report that their sexual experiences were intensified early in their chemsex practice. They reported feeling more confident with their partners, feeling like they are sexually attractive and overcoming their barriers to sexuality. The intensification of methamphetamine use and, in particular, injection change the positive perception of sexual life. Thus, for some participants, substance use takes more space and their sexual experiences become less satisfactory.
Practical implications – Participants report the services that address the phenomenon of chemsex are still scarce in Quebec province. In addition, the few services available aim to relearn a sober sexuality. However, mourning of the positive aspects of chemsex on sexual experiences seems still very little discussed. Greater consideration of positive chemsex experiences is needed in services that address this issue.
Originality/value – This project documented the perception of pleasure related to sexual practices among regular methamphetamine users. Their perception of pleasure will help develop services adapted to their reality.
Keywords Pleasure, MSM, Chemsex, Addiction services, Methamphetamine use, Sexual services
Paper type Research paper

Introduction
In the West, substance use rates among men who have sex with men (MSM) are greater than those observed among their heterosexual peers (Bourne et al., 2015; Bourne and Weatherburn, 2017; Keogh et al., 2009). Substance use among MSM is often associated with sexuality and, over the past few years, chemsex and its consequences are being increasingly documented in this population (Giorgetti et al., 2017; Maxwell et al., 2019; Foureur et al., 2013; Lyons et al., 2013). This chemsex phenomenon is defined as the use of certain substances in order to prolong, intensify and diversify sexual experiences (Bourne et al., 2015; Schmidt et al., 2016). According to the definitions used, chemsex is limited to certain specific substances, namely methamphetamine, mephedrone, ketamine and GHB/GBL (Bourne et al., 2015; Schmidt et al., 2016). These substances are often combined and may be accompanied by a misuse of erectile dysfunction medication, and interactions that increase health risks (Hammoud et al., 2018; Giorgetti et al., 2017).

In several countries, such as Canada, methamphetamine use among MSM has become an important public health concern and is associated with chemsex (Hopwood et al., 2016; Schmidt et al., 2016; Trottier et al., 2016). The proportion of MSM who report having used methamphetamine in the last year varies greatly, from rates of 5 per cent reported in a survey conducted in 44 European countries (Schmidt et al., 2016) up to 18 per cent reported in a survey conducted in Florida (Forrest et al., 2010). In Canada, in an MSM population clinic,
methamphetamine use in the last year increased from 9.8 per cent in 2007 to 18.7 per cent in 2014 (Trottier et al., 2016). These rates of methamphetamine use are higher than those observed among heterosexual men (Hopwood et al., 2016).

To this day, although legitimate, chemsex has been mainly modelled, studied and addressed from a harm and risks perspective, particularly with regard to HIV/AIDS and sexually transmitted or blood-borne infections (STBBIs) (Benotsch et al., 2012; Lyons et al., 2013; Reback and Larkins, 2013). The concept of pleasure associated with substance use, in general, is little addressed in the literature (Holt and Treolar, 2008). In the field of substance use, some authors see the need to further theorise the links between pleasure and substance use in order to develop studies on the issue that will allow the development of evidence-based interventions (Race, 2009; Holt and Treolar, 2008). Yet pleasure is a major component of substance use, particularly in the context of chemsex (Bourne and Weatherburn, 2017).

The pleasure found in substance use is associated with the sensations that substance use can create among people who use substances (Holt and Treolar, 2008; Weatherburn et al., 2017) as well as the context in which the substance use takes place (Holt and Treolar, 2008; Duff, 2008). In chemsex-related contexts, particularly in relation to methamphetamine use, pleasure is associated with disinhibition, a feeling of intimacy and connection (Bryant et al., 2018; Weatherburn et al., 2017), as well as an intensification of bodily sensations (Hammoud et al., 2018). However, little is known about the ways that experiences of pleasure evolve among MSM with regular methamphetamine use who have decided to modify their substance use habits.

A better understanding of the concept of pleasure associated with methamphetamine use could promote both an understanding of chemsex as well as the development of prevention methods and adapted services for people with problematic or at-risk substance use. The purpose of this paper is to document the perceptions of current and former methamphetamine users regarding their experiences of pleasure in relation to their use of this substance.

Methodology

Approach and study context

The data used in this paper come from the qualitative component of the Meth@morphose project. This project aims to create a round table gathering different stakeholders involved in Montréal healthcare (community members, clinicians, healthcare professionals, managers, leaders in public health) in order to reflect on the current state of the services offered to MSM who use methamphetamine as well as ways to improve these services. The qualitative component of the Meth@morphose project is exploratory in nature and rooted in a community-based research approach, involving all stakeholders in all stages of the research process (Otis et al., 2015). This project has received ethical approval from the local research ethics committee (Project number CHUS-2017-694) and the research committee of the associated community-based organisation.

Participants

In total, we met 17 MSM who use methamphetamine, including 9 current users and 7 former users. Participants were recruited through social media advertisements posted by the partner organisation, through other community organisations working with MSM, and through the snow-ball technique. Participants had to be at least 18 years old or older, have had sexual relations with another man during the last year, had used methamphetamine during the last year (current users) or had ceased use for at least 12 months (former users). All participants accepted being a part of the study and signed a consent form. Participants received a compensation of Canadian $40 for their time.

Data collection methods

Focus groups were chosen as the data collection method because the goal was to bring forward different visions of the same issue (Krueger and Casey, 2015). In this case, it was a question of
experiencing the perceptions that MSM had of their current or former methamphetamine use. Participants were divided into two focus groups based on whether they were currently using \( n = 9 \) methamphetamine or not \( n = 8 \), allowing for a consensus to emerge. Discussion themes dealt with their vision of methamphetamine use and the consequences, negative and positive, of methamphetamine use on their lives. Participants who were not comfortable with taking part in a focus group were offered the possibility of participating in an individual interview instead. Only one participant took advantage of this opportunity. Participants also had to complete a short sociodemographic questionnaire. All data collection activities were held in a room located in a Montréal community organization offering services to MSM.

Analysis

The audio interviews were subject to a thematic analysis aided by the qualitative data analysis software NVivo 12. An analysis grid was created based on the research objectives as well as early emerging material (Miles et al., 2014). This analysis grid was discussed between the first and third author in order to clarify, validate and ensure thematic reliability. Only content related to the concept of pleasure is presented here.

Results

Sample description

Participants were 35.3 years old on average (24–55 years old). In sum, 15 participants identified as gay, and two as bisexual. In terms of their relationship status, nine participants were single and six were in a relationship. Among those in a relationship, five were in a relationship with another man and one was in a relationship with a woman.

Initiation and evolution of chemsex

A consensus emerged among current and former methamphetamine users: use of this substance as well as sexuality are both intimately linked to pleasure. Among the participants of our study, the experience of pleasure in regard to methamphetamine use follows a dynamic trajectory in which it is possible to observe an evolution and a progression in methamphetamine use and in sexual practices. Four themes related to pleasure highlight this evolution: the pleasure associated with sexual practices and their effects; the pleasure associated with one’s relationship to oneself and to others; the pleasure associated with injection; and the decrease in pleasure associated with the consequences of substance use and the necessity of service use.

Pleasure associated with sexual practices. The majority of MSM in this study used methamphetamine in a sexual context for the pleasure it procures. Initiation to methamphetamine usually occurs through friends or acquaintances during “sex parties” or in spaces where chemsex is practised, such as in saunas. First experiences with methamphetamine gave the impression that sex is more attractive, more intense, even better or even less boring. By using methamphetamine, they perceive an improvement in their sexual performance, accompanied by a marked increase in their energy levels:

Someone probably gave it to me in the sauna, I was curious because I saw what it did to him and the sex seemed a thousand times better […] There’s a sexual fulfillment and a loss of inhibition. […] It becomes less platonic.

Methamphetamine use has multiple effects that impact pleasure during chemsex which leads MSM to maintain their methamphetamine use. Among the positive effects, MSM mentioned that methamphetamine gives them an energy that they normally do not have, allowing them to have sexual relations that can last for hours, even days, and with multiple partners. Concentration is also another appreciated effect of methamphetamine and allows them to fully enjoy the pleasure associated with chemsex. In addition to these effects, euphoria, disinhibition, increased self-esteem and an improvement in performance are all mentioned by participants. MSM also note that methamphetamine gives them the impression that they
are not too intoxicated – they appreciate this substance because it lets them stay focussed on the sex:

Crystal is like a way out. It actually keeps you from feeling too buzzed but helps you focus and set aside your problems. Except it helps me focus on the discussions we were having or on getting laid, but I would think of nothing else but that.

Others consider that, under the effect of methamphetamine, they discovered new sexual abilities. Methamphetamine would allow them to diversify their sexual practices, providing them with a certain pleasure. This diversification of sexual practices was sometimes expressed by risky sexual encounters that could be managed by using treatments such as pre-exposure prophylaxis (PrEP) or post-exposure prophylaxis. For example, for one participant, condom use diminishes not only sensation, but also the intimate aspect of the sexual encounter. For this reason, he preferred not to use a condom during his sexual encounters and instead opted for PrEP:

Me and condoms, I went 37 years without touching another man, so when it was time, when it comes to me and rubber, I have no desire to even touch a rubber. I want to feel a real man. It’s not really for the disease, but I’m happy we have pills [PrEP] – when the time comes, I don’t want rubber.

Pleasure associated with one’s relation to self and to others. This relationship to others, but also to oneself, takes an important place in participants’ discussions. Some explained that their chemsex practices lead to them develop a stronger acceptance of their sexual orientation or of their gender identity, which plays an important role in their experiences of pleasure. Certain MSM also explain that their reasons for using methamphetamine have evolved, without necessarily explaining how, after they came to accept their sexual orientation or gender identity. As explained by a gender fluid participant, before accepting their sexual orientation and gender identity, they would not dare go out and be identified as a gay person – for them, their reasons for using methamphetamine were mainly related to coping with gender identity. However, after accepting themselves, their reasons for using and their means of doing so changed:

I didn’t accept that I was gay, I was in a small town and I wouldn’t dare go into a gay bar – I told myself that others would see me, and everyone would know. But once I managed to accept and accept myself as I am, when I am with a man, I am a man, when I am with a woman, I am a woman. So, I’ve accepted, I am comfortable with myself and now I no longer use in the same way.

Combined with self-acceptance, these sex parties also facilitate the development of social relationships. Besides from the sex, the parties serve as a way to socialise in a precise context, allowing for discussion about shared interests, amongst other things:

My entourage is very hetero, all my friends have kids, we see each other on weekends and we have dinners, but having friends like me who have HIV and a good life, all of a sudden it was like, “oh, so there are people like me” and that’s the gathering effect that happens [with his Chemsex partners].

The pleasure of using methamphetamine can also be associated with the various social encounters with multiple partners that may take place. For some, having multiple partners in one night heightens the pleasure of using methamphetamine. For others, chemsex has allowed them to meet men they would usually consider out of their league:

With crystal, I feel like there’s a sort of self-esteem that sets in. I’m not particularly buff – I’m overweight – and all of a sudden, me who never takes off his t-shirt and who keeps his underwear on, I could end up completely naked and it wouldn’t bother me at all. So, there’s like an inhibition that’s there and that leaves. There’s also, sexually, it’s a group thing, and then, I’m having sex with really hot guys and I suddenly have access to guys who are out of my league and it’s like, “my god, I would never had had the chance to have sex with such hot guys” but it’s because of the [methamphetamine] use. It brings a power and an intensity that makes the sex better.

Pleasure associated with injection. The experience of methamphetamine injection (slamming in UK usage) may bring up mixed feelings among MSM. In the Montreal context, Francophone MSM have created the verb “slamer” which we translate here by slam (Canadian usage). Among those who progressed to injecting methamphetamine, they described their sexual experiences as extraordinary and were searching to regain that intense
pleasure each time they had chemsex. Finally, the transition to injecting helps push one’s personal limits:

I had a crazy good time [with slam]. Even in regard to my sexual practices, there’s no more barriers, you always want to push your limits further, but there are no limits.

For others, injection generates feelings of ambivalence ranging from fear to curiosity and excitement. Injecting can be seen as an exciting practice, and some eroticise the act of injection, provoking physical reactions of excitement. As explained by one MSM, his relationship with injecting had always been ambivalent. On one hand, he had always wanted to try, but on the other, he was afraid. However, whenever he thought of injecting, he could get an erection just by thinking about it:

I’ve always had a love-hate relationship with [injected] crystal. I knew it was like, a drug in a class of its own. It always made me scared, but at the same time, it was always attracted to it. It disgusted me, but it also got me hard.

Perception of substance use-related consequences, decrease in pleasure and service usage. Perception of substance use-related consequences. Methamphetamine use is not without consequences for the MSM encountered in this study. For some, despite certain negative consequences related to their substance use, including STBBIs, the concept of pleasure remains central. Among these MSM, pleasure is at the heart of the decision to continue using as long as a feeling of control and security remain present. They will explain the importance of knowing one’s personal limits so as not to experience consequences such as financial hardships or behaviours that are risky to their health:

I often hear: “stop”, but stopping isn’t fun. So why not take control of our [methamphetamine] use? For me, it has to be fun, it must not cause pain. I say no, because I want to continue and I want to have pleasure. So, there has to be a change in the way we see Tina [methamphetamine]. I know my limits and I know why I use.

Nonetheless, for those who have experienced significant consequences from their methamphetamine use, the way they see their own methamphetamine use becomes negative. Some will mention “a descent into hell”, characterised by financial, social and sexual loss: losing their jobs, losing their homes, breakups, STBBIs or HIV, etc.:

I knew crystal with a friend who came here for three weeks during which we were on crystal non-stop. Those three weeks were [...] I had everything when my friend arrived, I had a car, a job, a home, a family, the whole deal. And at the end of three weeks, I had nothing left and I was on the street.

The perception of loss of pleasure and service usage. Multiple participants concluded that it was worth reducing, or even stopping, their methamphetamine use. When they wanted to start the process of seeking help for their methamphetamine use problem, the MSM in this study explain that they do not know which services to go to. According to them, there are very few services in Montreal, let alone in the other cities of the province of Quebec:

It’s not just a question of environment, it’s also a question of information. We don’t know where to go, where to send us when we need help.

For those who accessed services, the services were very little adapted to their reality. In effect, stopping methamphetamine use signifies the loss of the pleasure associated with the use of this substance, notably in regards to their sexuality. In consequence, participants spoke of needing to mourn their sexuality – an issue not dealt with in most therapeutic follow-ups. MSM insist on the importance of taking into consideration ways to rediscover the pleasure and sexual fulfillment felt after methamphetamine use. They also believe it is important for different treatments to address ways to reconstruct one’s social network:

When you’re no longer into [methamphetamine use], you try to keep your friends, so you propose activities like going to the movies, but they’re not there, they’re partying. Even when I’m on holiday for a while, you try and organise a dinner, but it never works. At one point, you realise, OK, our paths are growing apart. So there’s a lot of mourning to do with certain friends and it’s hard. I also had to block certain contacts that I used to use with before. For someone whose only network related to [methamphetamine] use, it must be terrible. So it’s important to take in account in treatment.
Discussion

The goal of this paper was to document the perceptions of pleasure of current and former regular methamphetamine users in relation to their use of this substance. We observed that the pleasure associated with methamphetamine use was intimately linked with the sexual encounters that participants experienced while under the influence of this substance. Participants’ narratives about pleasure make links between pleasure and psychoactive substance use in general (Holt and Treolar, 2008; Duff, 2008; Weatherburn et al., 2017). However, methamphetamine use in a chemsex context generates additional effects which are related to exceeding the sexual limits of substance users. This can lead to risky sexual behaviour as well as dysfunction in different areas of participants’ lives. Regardless of whether participants are former regular users of methamphetamine or current regular users, they described different dimensions of pleasure associated with their substance use. However, the sexual and social dimensions are those for which participants experience more pleasure.

This paper offers a different angle of reflection regarding pleasure among regular methamphetamine users. To date, most studies examining the relationship between methamphetamine use and sex have focussed on HIV risk behaviours and other STBBIs (Benotsch et al., 2012; Lyons et al. 2013; Reback and Larkins, 2013). Moreover, in our study, we have collected the experience of MSM with regular consumption of methamphetamine, which is a strength in itself. However, this strength is also a limitation because regular use of methamphetamine tinges the participants’ experience of pleasure and its evolution. Although this study is based on a small sample, our observations are consistent with some researchers and stakeholders that consider it important to pay more attention to the links between pleasure and substance use, especially in a sexual context (Lea et al., 2019; Hickson, 2018; Winstock, 2015). Moreover, our research could inform the development of future larger studies in order to verify our findings.

These findings question the content of methamphetamine use prevention campaigns, which mainly target the negative potential consequences of this form of substance use (Douglass et al., 2017). By not taking into the account the pleasure associated with the use of this substance, these campaigns are likely to fail. Promotion of safe sexual behaviour, whether through condom use or through biomedical prevention strategies, such as PrEP or prevention treatment, should consider the dimension of pleasure related to methamphetamine use. The experiences described by the participants in this study often reflect the intention to use methamphetamine to overcome sexual limitations and included various behaviors that may be classified as at risk for HIV transmission and other STBBIs, including sex with multiple partners and without a condom.

The literature on the sexualised use of psychoactive substances shows that public health stakeholders are increasingly concerned by a practice known as slam – the injection of methamphetamine or mephedrone in a sexual context (Foureur et al., 2013; Lyons et al., 2013). Certain participants of our study reported on the sexual intensity that slam brought them, as well as a sort of eroticisation of this practice. However, the concept of pleasure, especially sexual pleasure, in relation to substance use, is seldom addressed in sexual health and addictions services (Holt and Treolar, 2009).

In addition to preventative interventions for substance use and risky sexual behaviour, interventions that aim to change substance use behaviours among MSM with problematic methamphetamine use face a major challenge. How do we accompany MSM who wish to reduce or stop their methamphetamine use entirely in the mourning of pleasure associated with substance use and, especially, with sex under the influence of methamphetamine? Which approaches do we use? How do we promote the revival of sober sexuality? For the moment, there are few answers to these questions. Some innovative addiction intervention programmes have been developed to approach sexuality from a pleasure perspective, either from general substance users (Edwards 2012; Robinson et al., 2002, 2011), or specifically from MSM consumers (Anderson, 2009), even see crystal meth users (Reback et al., 2014). However, these have yet to be evaluated and their effectiveness has not yet been proven.
References


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The role of critical moments in young offenders’ drug-using trajectories

Franca Beccaria and Sara Rolando

Abstract
Purpose – The purpose of this paper is to explore the relationship between drug use and offending by using the concept of critical moments as an analytical tool.
Design/methodology/approach – In total, 41 semi-structured individual interviews with young people (15–25 years) using drugs and in touch with the criminal justice system (CJS) were conducted.
Findings – Analysing critical moments in young people’s drug use contributes to explaining some of the multiple, possible links between drug use and offending. Institutional factors emerged as important, as well as social and economic inequality. This was in particular clear when comparing students’ and immigrants’ trajectories.
Research limitations/implications – Limitations are due to the difficulties in getting access to prisoners and young people in touch with the CJS and the possibility to meet them only once with time limits due to the setting.
Practical implications – Prevention intervention addressed to this target group could take young people’s social contexts and everyday life situation into consideration.
Social implications – To decrease both offending and drug use, structural measures aimed at decreasing social inequalities would be more effective than punishment.
Originality/value – The study proposes a practical way to analyse narratives of young people who have experienced both drug use and offending and to show the importance of socially structured patterns without reducing the complexity of the topic.
Keywords Qualitative methods, Criminal justice system, Young offenders, Critical moments, Drug and crime, Drug trajectories

Introduction
The connection between drug use and offending or between drugs and crime has been debated in the sociological and criminological field since the beginning of the twentieth century with attempts to determine a causal direction (Beccaria and Prina, 2016; Laidler, 2016), but without definitive results (Laidler, 2016, p. 95). Numerous studies have shown a statistical association between drug use and offending. The great majority of these studies have taken a point of departure in people imprisoned or enrolled in drug treatment. In both cases, strong correlations were found between drugs and crime (Bean, 2014; Nurco et al., 1985). Allen (2007), however, emphasises that the correlations do not necessarily mean that “drugs cause crime” or vice versa, but simply that the two phenomena often co-exist. On the other hand, researchers also hypothesise that a range of “third variables” associated to “an underlying lifestyle” are the cause of both offending and drug use (Allen, 2007). Following this, many factors have to be taken into consideration to understand the relationship between drug use and offending, including type of drugs used, motives of drug use (recreational, pharmaceutical, etc.) (Allen, 2007), the context for drug use (Zinberg, 1984), what type of offending one is involved in (selling, being part of a gang, etc.) (Howell and Decker, 1999), etc. To provide an even more complex picture, the drug market has to be included as well, since the relationship between the consumer and the supplier is not always clear (cf. Parker, 2000), but also because both consuming and supplying can be the entry into the criminal justice system. Exploring drug use trajectories and their interconnections with offending trajectories, therefore, appears both
In general, drug use and offending trajectories are characterised by transitions, often triggered by particular episodes or experiences (Hser et al., 2007; Allen, 2007). These key moments in an individual’s biography have been differently defined in the scientific literature, as, for example, “turning points” (Mandelbaum, 1973), “career breaks” (Humphrey, 1993), “fateful moments” (Giddens, 1991), or “stressful events” (Pearlin, 1989). In the present work, we have borrowed and adapted Thomson et al.’s (2002, p. 339) concept of “critical moment” as a particular event having important consequences on the biographies of individuals and their identities. We choose this concept as appropriate to uncover the role of social structures and cultural resources on both drug use and offending trajectories, thereby potentially providing new insights also on their many possible relationships. The concept of “critical moment” is, however, not exempt from criticisms. In particular it has been questioned how the events highlighted in narrative interviews as “critical moments” can be interpreted in relation to what really happened. However, as Bruner (1987, p. 31) emphasises: “ways of telling and ways of conceptualizing that go with them become so habitual that they finally become recipes for structuring experience itself, for laying down routes into memory”. We therefore understand the description of a critical moment in the interviewees’ narratives as “a middle path between the way young people talk about their lives and what actually happens to them” (Thomson et al., 2002, p. 351). From an analytical point of view, we adopt the definition of “critical moment” as “an event described in an interview that either the researcher or the interviewee sees as having important consequences for their lives and identities” (Thomson et al., 2002, p. 339). Furthermore, Thomson et al. (2002) proposes two possible ways to analyse critical moments. The first way is by focussing on the interviewees’ perceptions of being in control of events. From this point of view, critical moments can be mapped along a continuum, whose extremes are represented by “choice” and “fate”, respectively. A second way of mapping critical moments is to analyse which of them often recur together, that is, investigating “clusters” of critical moments. This latter kind of analysis – which we use in the present study – indicates not only the links between critical moments and developments of drug use or offending trajectories, but also links with socio-economic conditions, thereby enabling comparisons to be made across individual narratives and therefore also to increase a more general understanding of how and why young people respond in a different way to similar events.

In the Results section, we will first provide an overview of critical moments that emerged from the interviewees’ narratives, then we will analyse the two main individuated clusters of critical moments.

Sample and methods

The 41 qualitative interviews with drug experienced young people in contact with the CJS were conducted in several different places. The recruitment and interviews took place between September 2017 and July 2018.

We started out by getting authorisation from the Penitentiary Administration Department and the Minors and Community Justice Department. We recruited mainly in North-West Italy within four types of services: detention centres for minors; services in charge of administering external penal sanctions – i.e. measures alternative to prison – for adults and minors; a unit of the addiction services reserved specifically for minors with penal problems; and prisons. In total, seven different institutions agreed to participate, as described in Table I. More institutions were contacted, but some did not have detainees with the required characteristics; in others, professionals were too busy to organise the interviews, or some institutions reported difficulties convincing young people to participate.
Professionals who helped the researchers with the recruitment were provided with a short description of the research design and aims together with a consent form. In the case of minors, the consent required the signature of a parent or guardian—which made it more difficult to get minors involved. Despite the initial difficulties in getting appointments, in some detention centres, once we started to conduct interviews other young people, who formerly had not given their consent, asked to be interviewed. It was particularly difficult to reach female interviewees, which is not surprising since women represent only a minimum percentage of the target group[2].

The interview guide consisted of a list of topics aimed at stimulating a spontaneous narrative by the interviewee. They included two main areas for investigation: the drug use trajectory and their involvement in any kind of drug prevention initiative/treatment path within the CJS. Offending was also investigated, but mainly in relation to drug use rather than as a topic per se. In order to focus on “critical moments” we asked both specific questions related to events and time and asked the young persons to draw a timeline graph and add important events on the line and comment on it.

All interviews were conducted by the authors and lasted on average 40 min. They were audio-taped and verbatim transcribed. The analysis was performed using ATLAS.ti, a computer-assisted qualitative data analysis software. The coding process — intended as both data and theory driven — focussed specifically on emerging critical moments and particularly on their impact on both the use of drugs and engagement in offending. Table II provides an overview of the 41 interviewees. Most interviewees are young male adults aged 18–25 detained in prison for dealing or robbery. In half of the cases, this is not the first penalty; 17 out of 41 young people are immigrant, including 7 illegally present in Italy; and 6 out of 41 are second generation.

Results

Mapping critical moments in drug use and offending trajectories

We will start by mapping out different kinds of critical moments that occurred in the interview and construct overall categories related to them. As shown in Table III, we have identified six

<table>
<thead>
<tr>
<th>Table I Recruitment</th>
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<tbody>
<tr>
<td>Recruitment channel and city</td>
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<tr>
<td>A special section of the prison called “Attenuated Custody” (ICATT), Padova</td>
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<tr>
<td>A special unit of the local public addiction service called Spazio Blu (Blue Space) targeted at young users in touch with the CJS, Milano</td>
</tr>
<tr>
<td>Juvenile penitentiary institution (IPM), Torino</td>
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<tr>
<td>Prison, Biella</td>
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<tr>
<td>Prison, Fossano</td>
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<tr>
<td>Juvenile social services office of the justice Department (USSM), Torino</td>
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<td>Interdistrict office for external penal execution (UEPE), Torino</td>
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<tr>
<th>Table II Sample description</th>
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<tr>
<td>Socio-demographic</td>
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<tr>
<td>Sex</td>
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<tr>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Type of crime and penalty</td>
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<tr>
<td>Crime</td>
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<tr>
<td>Dealing</td>
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<tr>
<td>Robbery</td>
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<tr>
<td>Armed/Aggravated robbery</td>
</tr>
<tr>
<td>Aggravated injuries</td>
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<tr>
<td>Others (trafficking, rape, aggression, etc.)</td>
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different categories. We will describe in more detail how the different categories were described as “critical moments” by our interviewees.

The first category we have identified is family. We noticed in the interviews that – in line with previous studies (Newburn, 1999; Allen, 2007) – a high number of interviewees had separated or divorced parents. According to our interviewees, separation or divorce resulted in an increase in the use of substances not only in order to cope with the upset, but also because of feelings of decreased control. Another result of having separated parents was possibility of difficult relationships with stepparents. A recurrent feature found in our data was difficulties with parents/stepparents that resulted in fights and/or abuse of young people. Problematic relationships with parents or stepparents also resulted in running away from home, another cited critical moment. This was the case, for instance, of one interviewee, who was “turned out of the home” by his father when he was caught using drugs, resulting in an increase of both drug use and crime. A last emphasis was shortage of money in the home, which, for Carlo, Matteo and Paolo, was a reason to start drug dealing in order “to get things that others had”.

A second category is relationships with peers/partners. Meeting new friends was frequently quoted by our interviewees as the event initiating the onset of drug use or the use of new substances; equally, friends can introduce a young person to offending, as Andrea says in the following quotation:

> I met a friend of mine, who introduced me very much to the criminal world, since hanging out with him, he showed me things that I never saw [before]. I’m not a rich kid but neither one living in public housing. […] He introduced me to people who spent more time in prison than out. (INT. 8_BP2_M_17)

Losing a meaningful relationship with a friend can be a terrible blow for a young person, as the following quote suggests, when Said heard – after release – that his friend had died:

> Since then, I shut myself at home for almost a month. After that month, as soon as I left, I went to look for adventures. I started doing things […] I mean, I was no longer interested in policemen, judges […]. This is what I got wrong. I did things without thinking about consequences. Because you come to a certain point that you do not care anymore, because you say: “In any case, [things can’t go] worse than in this way”. (INT.02_PRI_M19)

The quote shows how friendship can be so important as to over-ride the sense of everything else, including the risk of getting arrested, therefore possibly also increasing offending. This resembles Allen’s (2007) observations about young offenders dealing with bereavement. The influence of boy/girlfriends is similar to that of friends. However, in our predominantly male sample the most recurrent pattern, i.e. having/losing a girlfriend often includes another specific element, that is women’s role of limiting their partners’ consumption, and, in this case, also crime activities. Furthermore, losing meaningful relationships – parents, friends, etc. – is among the reasons why immigration (third category) represents, for all those who experienced it, a critical moment. In the narratives, moving country often contributed to an increase in the use of illicit drugs and marked the start of offending, mainly dealing. This multifaceted relationship will be addressed further in the cross-reference.

A fourth category is related to school and education. Especially leaving school – which implies having more time to do other things, such as using drugs with friends – and moving school.

<table>
<thead>
<tr>
<th>Table III</th>
<th>Map of critical moments emerging from interviews</th>
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<tbody>
<tr>
<td>Family</td>
<td>Separation/Divorce of parents</td>
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<tr>
<td></td>
<td>Death of parents</td>
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<td></td>
<td>Fight with parents/stepparents</td>
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<tr>
<td></td>
<td>Run away from home</td>
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<td></td>
<td>Becoming parents</td>
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<tr>
<td>Relationship</td>
<td>Meeting new friends</td>
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<tr>
<td></td>
<td>Death of friend</td>
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<tr>
<td></td>
<td>Breaking up with girlfriend/boyfriend/partner</td>
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<tr>
<td>Education</td>
<td>Changing school</td>
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<tr>
<td></td>
<td>Leaving school</td>
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<tr>
<td>Work and income</td>
<td>Losing/Getting a job</td>
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<tr>
<td></td>
<td>Starting to deal emigration</td>
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<tr>
<td></td>
<td>Moving country</td>
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<tr>
<td></td>
<td>Change of substance</td>
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<tr>
<td></td>
<td>Becoming a daily user</td>
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<tr>
<td></td>
<td>Starting to use cocaine</td>
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<td></td>
<td>Starting to use crack</td>
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<tr>
<td>CJIS</td>
<td>Being caught</td>
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<tr>
<td></td>
<td>Receiving a criminal conviction</td>
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<tr>
<td></td>
<td>Entering/Exiting from prison</td>
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<tr>
<td></td>
<td>Entering/Exiting from therapeutic community</td>
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</table>
For instance, Antonio, when he attended the first year of secondary high school, was forced to move schools by his parents after they discovered that he smoked cannabis. However, in the new smaller school, his use of cannabis increased and in addition he started to deal to schoolmates, according to what he reported, as a consequence of the increased need of money.

Another category is related to the employment status and thereby also having an income. Getting or losing/not finding a job is described as having an impact on drug use and offending trajectories. In the following quote, Ergi explains how working is a source of satisfaction and identity, thereby decreasing the need of using drugs:

For a while I did not [use drugs] because I had pulled myself out, I was no longer interested in that world, let’s say, because I was fine, I was working, I had my money [...] When I started [to use drugs] it was because I had no job and doing nothing takes you on the wrong path. On the contrary, in that period [when I got the job] I was happy because I had my things, I was working – I worked a lot, 10-11 hours every day – but it was fine. (INT. 1_BP1_M_23)

However, when Ergi’s contract was not renewed and he could not find another job, he started to use cocaine again and to deal as a source of income. While dealing was seen as an income, as well as a way to support one’s one drug use, starting to deal was also reported by several interviewees as increasing the use of drugs. First, because it was difficult to abstain when having drugs in one’s possession to deal and, second, because dealing was stressful and required the use of drugs to face it. According to Paolo, this is especially true in the case of cocaine, as it is well known that different types of drugs have different effects:

Dealing cocaine you always are in bad situations. Bad things always happen, when dealing such a substance. Then you get nervous and you fall into it again. When you have problems, you face them with a cocaine strip. (INT. 33_PRI_M_22)

A sixth category focuses specifically on substances, including descriptions of change in intensity of drug use as well as change in the drugs used. Cannabis was the most used substance in our sample, and becoming a daily smoker emerged in many cases as a critical moment in that it increased the need for money to buy cannabis, which, in turn, could possibly initiate dealing in order to get free supplies. Starting to use cocaine, the second most used substance in our sample, emerged as another critical moment in our interviewees’ description of their trajectories, since according to the interviewees, it is both more expensive and addictive. Furthermore, interviewees often reported that use of cocaine requires the combined use of other substance such as cannabis, alcohol or heroin. Finally, differently from cannabis, cocaine was reported by several interviewees as having a direct causal nexus with their offending, because of its pharmacological properties:

Joints did not make me do crimes [...] when I smoked I was too frightened to do it [...] but when I took cocaine I was the one to say: “Let’s go, we need money” [...] It made me feel powerful, very awake. (INT. 41_CO_F_18)

Starting to smoke crack cocaine instead of snorting powder cocaine is considered another “jump”, as Paolo called it, in drug use trajectories, with consequences also on offending trajectories. Crack, indeed, was reported as more addictive than snorted cocaine and as leading to an exponential increase in amounts taken.

The last individuated category is getting in touch with the CJS. While this obviously represented a critical point for all our interviewees, it did it in different ways according to different sanctions applied to the young person as well as to personal social resources. Being caught was usually reported by our interviewees as decreasing both drug use and offending, at least for a while. However, cases of those reoffending after a first sentence prevailed in the sample, reflecting a rather common fact within the CJS (Beccaria and Rolando, 2017). In general, entering prison more frequently resulted in a decrease or cessation of drug use, when compared to entering alternative measures, such as home arrest or community services. This is mainly because of reduced availability of illegal drugs and fear of consequences on the punishment within the CJS if caught using drugs, such as losing the right to obtain home licences. Some detainees considered imprisonment an opportunity to stay away from drugs for a while, thereby stressing the influence of the context on their drug use. Indeed, once released, so they told us, it was difficult to maintain abstinence. For this reason, release represents another critical moment when the likelihood of
using drugs increases, especially in the absence of social reintegration activities, as will be better explained in the following section.

The role of socio-economic conditions: two types of clusters of critical moments

Following Thomson et al.’s (2002) suggestion, in the following, we will look into the most frequently described links between critical moments, called “clusters”, in order to unpick in more detail how these interact with drug use and offending trajectories in specific subgroups. Two main types of clusters emerged from the data, related to the two specific target groups of our sample: young people born in Italy, who were under alternative measures; and young illegal immigrants detained in prison.

Young people enrolled in Spazio Blu – a special unit of a local public addiction service situated in Milan and targeted at young offenders – and a few other interviewees sentenced to alternative measures were largely students. The descriptions of critical moments in the interviews from this subsample individuated a particular cluster of critical moments represented in Figure 1.

Many of them were “ordinary” students – that is not necessarily with poor school performances – belonging to “ordinary” families, not necessarily with low economic or social resources. However, a recurrent feature was that parents were either separated or divorced and that they did not exercise a high level of control over their children. In this subgroup made up of Italians or second generation immigrants, the onset of drug use often coincided with the beginning of secondary high school, at the age of 14–15. Here, they met new friends at school and experimented with cannabis. This was reported as something really “ordinary” and therefore, somehow, ineluctable:

I do not remember it very well, it is like driving, it’s not that I remember […] but I think the first time is something you do not look for […] when a friend offers it to you. (INT. 13_ALT_M_21)

Continued use of cannabis was as seen an occasional activity for mainly recreational purposes (e.g. increasing fun). However, after a while, from between a few months to a few years, they all became daily users. The young interviewees described how, during this period, reasons for using cannabis changed, from fun and smoking to intoxication with friends, to smoking alone, especially in the evening, in order to get to sleep. Cannabis was also reportedly used to increase self-confidence and school performances. Antonio, who is a university student with good school performances, reported smoking cannabis in order to prevent anxiety and to study better (INT. 14_ALT_M_20). Luca told us that it gave him “much self-confidence, both in terms of image and psychological self-confidence” (INT. 13_ALT_M_21). They also reported in the interviews, that when they ended up smoking joints instead of cigarettes, many times a day, reaching in

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**Figure 1** First type of cluster

![Diagram](image)
some cases 10 grams a day, their need for money increased too. This was reported as one of the main reasons for starting to buy larger amounts of cannabis, partly in order to sell to friends, thereby saving up or getting personal doses for free. However, once having discovered how you can make money easily, the purposes of dealing can go beyond the original ones, as Marco said:

After that, when I saw that to get money it was sufficient to do so, I became more obsessed – so to speak – by money than by the drug itself. (INT. 39_ALT_M_19)

Becoming the school dealer can even increase popularity, which was the case with Massimo, who especially liked being appreciated and respected as the school dealer, a sort of social supplier of recreational drugs and a way to increase his self-esteem by getting a role in society:

Being able to do something that would make me feel more adult, that would make me be noticed, also because I had serious problems of bullying before […] Then I realized that the dealer was just, almost a role, in the school society. I mean […] there was the nerd, the bully, the normal guy and the drug dealer, who - as opposed to how he was seen years ago […] when he was a bad person, that is, even the consumers were disgusted by the drug dealer, especially because the drugs were different. Now marijuana, let’s say it’s like alcohol for people. (INT. 40_ALT_M_17)

The fact of being denounced forced Massimo, as well as other interviewees, to become aware that, although use of cannabis is perceived as normal, dealing it is an illegal behaviour. This is often traumatic, but getting in touch with innovative services such as Spazio Blu – that is, receiving psychosocial support at individual as well as familial level (Rolando and Beccaria, 2018) – can become a resource in their biographies, both with respect to family relationships – parents are involved in the treatment path too – and to the discovery of alternative lifestyles through social activities, such as teaching children to skateboard:

While they (professionals) have also helped us to converse within the family, which […] is also useful for personal growth, for any situation. […] After probation, there would also be the opportunity to be paid by this association to do the lessons, which I like a lot, so I will probably continue it. […] To do sport is fruitful, it makes you stop thinking as much as drugs, much more in fact, and, in addition, it is healthy and funny. (INT. 15_ALT_M_19)

The second typical cluster emerged from narratives of a subgroup of young people who had illegally migrated to Italy, especially from North Africa. As mentioned in the previous paragraph, according our participants’ narratives, immigration increases the likelihood that young people start to use drugs or increase their consumption (Figure 2).

The interviewees provided several explanations for this. The increase in drug use, for instance, was explained by many as a consequence of being in Italy alone, out of parental control and in a

![Figure 2](image-url)
place environment? Where drugs are more accessible than in the country of origin. In addition, according to some North Africans, smoking hashish with fellow countrymen can be a way of joining the community of origin in the new country:

Since I came to Italy I found all the drugs I wanted, I found all the freedom I want. So I started to use cocaine also. (INT. 32_PRI_M_21)

Furthermore, a vicious circle was frequently reported about the work issue; getting a job without a residence permit is not possible according to Italian law, equally it is not possible to apply for a residence permit without a job. Therefore, according to this subgroup of interviewees, losing or not finding a job, on the one hand, fosters an increase in drug use aimed at coping with the privations and the anguish of a precarious life. On the other hand, it means that dealing can represent the only available opportunity to get an income, which, in turn, was mentioned as a factor increasing consumption because of the easy access to drugs. The following quotation is an excerpt from an interview with a 23-year-old young man who, waiting for a residence permit, ended up living on the street and dramatically increased his consumption of alcohol and Rivotril, a benzodiazepine:

I was a barber in Tunis, I knew how to cut hair, but I did not have any documents for which reason no one took me on, so I started selling a bit of hashish, I started selling, and using it at the same time. Then after 3 years I started using cocaine because I was handling it, I was dealing it. (INT. 03_CS1_M_23)

In turn, as the interviewees emphasised, having to manage substances increases amounts and frequency of consumption, which again made it more likely to be arrested. When talking about this critical moment, interviewees emphasised the role of specific substances, i.e. cocaine and crack – compared to cannabis – in decreasing their feelings of agency and control:

The monkey took me from the bottle[4]. When I no longer had the substance nearby, I started to go out to buy […] When I snorted, 3-5 grams were enough, when I started with the crack, I saw that 5 grams were not enough, I had to go and buy again, again, again. I was doing 35 grams a day. (INT. 5_CS1_M_24)

It is no coincidence that many of them reported that they were arrested precisely during a peak in consumption. For this reason, one interviewee saw the sentence as an opportunity to take a break from drugs:

If I had not come to jail, I do not know how I would have ended up. I would be dead somewhere! (INT. 03_CS1_M_23)

However, the concern of not being in control of their drug habit is especially relevant to release. Young immigrants were quite conscious that once got out of prison the problem of work would re-appear – even increased by having a criminal record – with the same influence on their drug use and offending trajectories:

I have to find my way out [of drugs]. Then you will see what I have to do outside. I would like to change my life, but let’s see […] It all depends if you can find a job. (INT. 34_PRI_M_24)

To sum up, looking at critical moments, two kinds of clusters were identified, related to two specific target groups: young students under measures alternative to prison, and young illegal immigrants detained in prison. Critical moments included in the two types of clusters highlight the role of diverse life contexts and socio-economic systems in modelling consumption and offending trajectories, as it argued in the following.

Discussion

We have used Thomson et al.’s (2002) concept of a critical moment as an analytical tool to investigate the drug use trajectories of young offenders in order to better understand a long-debated relationship between drug use and offending (Allen, 2007; Laidler, 2016). In particular, we have emphasised the influence of social and institutional dimensions on both drug use and offending trajectories, revealing also the role of social inequalities.

Our argument is that inequalities, first and foremost, are institutionalised. Our sample reflects a broader gap in the Italian law and CJS, where immigrants are over-represented in prison.
According to the last Report to the Parliament (DPA, 2016), they represented 37 per cent of the whole adult population detained in 2016, a percentage even higher among minors entering the first reception centres for minors (53 per cent in 2014) (Marietti, 2015). As scholars pointed out (Mosconi, 2010; Vianello, 2012), this is because they can rarely access alternative measures to detention, due to their lack of social and material resources (e.g. a house) required by the Law. This is particularly true for immigrants illegally present in Italy, for whom every kind of preventive, pedagogical and rehabilitation intervention risks being interrupted, thereby losing effectiveness, because of the threat of expulsion (Marietti, 2015). The vicious circle between residence permit and work contract illustrated above emphasises how the working sphere impacts both on drug use and on offending trajectories. On the one hand, motives to use drugs when you are unemployed are pharmaceutical – to cope with stress and anxiety – rather than recreational. On the other hand, in certain cases dealing drugs can be the only income opportunity at hand, maybe even a way to feel part of a community. Handling drugs, however, can easily lead to increased consumption and possibly also to trying out new drugs. In our data, shifts towards cocaine and especially crack were recognised by young offenders as a very negative critical moment leading to increased criminal activity and loss of control over drugs. All in all, the immigrants’ cluster shows that crime and drug use can be two aspects of the same social context, with bidirectional influences. Indeed most of these interviewees were already cannabis users – either recreational or daily – when they arrived in Italy; but in their countries of origin, they usually had not been involved in offending. However, they reported that the use of cocaine and especially of crack led some of them to commit more crimes or more serious crimes, due both to the disinhibiting effect of the substance and the increased need for money because of increased expenses. Furthermore, the use of crack, in particular, was reported by the interviewees as the reason why they were arrested, since they were not clear headed enough. A characteristic of this cluster of critical moments is the interviewees’ recurrent perception of lack of agency, understood as individual capacity to make their own choices and consequently to shape their life (Hitlin and Elder, 2007) such as getting a regular job and not having control over certain substances.

The students’ typical cluster, in turn, shows how drug use and crime can both derive from within a totally different social context, which needs to be understood by leaving aside the old definition of drug use as social problem (Hunt and Barker, 2001). Italian students’ narratives are close to that of most substance users who have social profiles that comply with social norms (Williams and Parker, 2001; Pearsons, 2001). In particular, their approach to the use of cannabis reflects the fact that also in Italy cannabis has undergone a normalisation process (Parker et al., 2002). This is reflected not only by the perception that everybody uses it, but also by the casual way in which some interviewees started to deal it, without any worry about possible consequences. Yet, consistent with its illegal status, cannabis users still face the threat of legal sanctions, especially those who decide to buy for their friends as well, because they have the right contacts or are the smartest in surfing the darknet. Penal consequences obviously entail a process of stigmatisation that can be very traumatic for young students (Lyons, 2006). However, Italian students are not likely to end up in prison for dealing, certainly not as a result of the first offence; it is more likely they will be put on probation, with the suspension of criminal proceedings (Law No. 67/2014, cf. Beccaria and Rolando, 2017). This measure usually includes a social service programme and a treatment path, which requires the young people’s agency – defined as “capacity, resistance and transition” (Hitlin and Elder, 2007, p. 182) – and can turn out to be a resource for those who already have some, e.g. a caring family (Rolando and Beccaria, 2018). From the narratives typical of this cluster, we can also get further information on the relationship between offending and drug use. Although many young interviewees stated that they had started to sell cannabis in order to maintain their own consumption, yet they also explained how, after a while, reasons to do it can change. That is to say that once you discover how easy it is to make money by dealing, it becomes tempting beyond the initial purpose. It can also be exciting – as well as drug use – and even socially gratifying.

The present study contributes to empirically explain some of the multiple, possible links between drug use and offending in the manifold contemporary social and institutional context, which makes it even less suitable to attempt to delineate a clear causal relationship (Allen, 2007). In addition, it suggests that social inequalities and perception of agency can explain drug use and offending trajectories better than single events or critical moments. The results also suggest that
in order to reduce both drug use and offending the most effective interventions should be done at social structural level in order to reduce the reproduction of inequalities in accessing social and economic resources (e.g. lack of jobs and/or house) and at the legislative level to eliminate the boundaries that impede the rehabilitation function that penalty should entail, in particular for marginalised people. In other words, measures alternative to prison should be made available also to immigrants. On the other hand, preventive interventions addressed to young offenders who also use drugs should be broad and inter-sectorial, they should encourage their agency, leaving the subjects to become an active part of the rehabilitation process, starting from their goals and their capacity for self-determination.

Notes

1. The project 768162/EPPIC, which has received funding from the European Union’s Health Programme (2014–2020). The content of this editorial represents the views of the authors only and is their sole responsibility; it cannot be considered to reflect the views of the European Commission and/or the Consumers, Health, Agriculture and Food Executive Agency or any other body of the European Union. The European Commission and the Agency do not accept any responsibility for use that may be made of the information it contains. See also www.eppic-project.eu

2. This is deductible from other data, though there are not precise data on this specific target (Rolando and Beccaria, 2018).

3. Quotations are accompanied by a code indicating the country, the interview number, the measure (home arrest (HA), therapeutic community (CO), prison (PRI), other alternative measures (ALT)), gender (M/F) and the age (no. of years).

4. In jargon “monkey” refers to abstinence, while the bottle refers to the way crack is smoked.

References


Further reading


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Enactments of a “holistic approach” in two Danish welfare institutions accommodating young adults with offending behavior and drug use experiences

Maria Dich Herold, Cecilia Rand and Vibeke Asmussen Frank

Abstract
Purpose – The purpose of this paper is to discuss how a “holistic approach” is enacted in two interventions accommodating the same target group, young adults with offending behaviour and drug use experiences, but offered in very different contexts, the Prison Service and the community. The aim is to show how enactments of a “holistic approach”, although similar on paper, differ in welfare institutional practices due especially to organisational and structural conditions.

Design/methodology/approach – The paper is based on qualitative semi-structured interviews and written material from and about the two interventions.

Findings – Different enactments of a “holistic approach”, due to organisational and structural conditions of the interventions, construct different possibilities for institutional identities. These insights could be useful to take into consideration when discussing prevention initiatives (in a broad sense) for young people with complex problems, including co-occurring offending behaviour and drug use experience.

Originality/value – Research with a focus on citizens with complex problems who do not comply with or conform to standard welfare institutions are limited. The authors contribute to this literature by focussing on young adults with offending behaviour and drug experiences.

Keywords Young adults, Prevention, Denmark, Holistic approach, Complex problems, Institutional identities

Paper type Research paper

Introduction
A “holistic approach” (Danish: “helhedsorienteret indsats”) has become a catchword in many different aspects of welfare policy in Denmark. In this paper, we discuss how a “holistic approach” is enacted in two different welfare institutions, which accommodate drug experienced youth in contact with the criminal justice system (CJS)[1].

In Denmark, the “holistic approach” as a concept appears in both social, health and legal rights laws (Harder and Nissen, 2013; Nissen and Harder, 2018; www.retsinformation.dk). One example is the Law on Social Services, which is the legal basis for welfare institutions that target marginalised or disabled citizens, including drug experienced young people. This law states that the starting point for all kinds of welfare institutional initiatives aimed at marginalised citizens has to be “coherent and holistic” (Law on Social Service, 1997), must take a point of departure in the citizen’s everyday life situation, and must involve the citizen’s own perspectives on what support is needed (Law on Social Services, Section III[2]). Historically, a “holistic approach” emerged within social work in the 1960s in Denmark (e.g. Harder, 2013; Olesen, 2013) and elsewhere (e.g. Pyles and Adam, 2016).
Nissen and Harder (2018) argue that particularly in the Danish context, a “holistic approach” has become a complex concept. In terms of definition, this concept has evolved in relation to societal and welfare state developments and therefore studying this approach is linked to developments in the welfare state, such as changes in social and health policies, legal changes, and implementation of new welfare services. A “holistic approach” is, in other words, not only written into Danish legislation and policies, but also stands out as a pivotal focus in contemporary Danish social work. Therefore, the intention to fully define what a “holistic approach” implies becomes an intricate task, particularly due to the complexity it entails and the diverse contexts (policies, research, social work interventions) in which it is applied (Nissen and Harder, 2018; Harder and Nissen, 2013), including that of interventions aimed at marginalised youth (e.g. Lau et al., 2017; Kjeldsen et al., 2015).

In addition to this, Nissen and Harder (2018) also argue that a “holistic approach”, despite developments of different and varied definitions within social work, is basically an approach which aims at including a variety of levels and perspectives in the process of defining and seeking solutions to different kinds of social problems (Nissen and Harder, 2018, pp. 29-30). Following this, we will argue here that, while both interventions under scrutiny in this paper aim at helping their target group by applying a “holistic approach”, their enactments of a “holistic approach” differ, in particular because of these interventions’ organisational and structural differences (cf. Weinberg, 2001), being prison and community based respectively. Importantly, it is not our aim here to offer a new definition of a “holistic approach”, but to analyse how the same welfare institutional concept is enacted in the context of two different welfare institutions. As part of this, we wish to discuss how these enactments may affect the young people enrolled in these interventions, particularly by enabling them to take up different “institutional identities” (cf. Gubrium and Holstein, 2001; Järvinen and Mik-Meyer, 2003).

A “holistic approach” is thus “in vogue” and recommended from many sides, including international research literature (e.g. Menon and Cheung, 2018). This paper, however, adds to the literature on holistic approaches by focussing not on the definition or guiding principles of a holistic approach per se, but on the enactments of this concept in institutional practices. As part of this we argue that its meaning is (differently) enacted in (different) institutional set-ups, and that only by investigating these enactments do we know what a “holistic approach” can entail and thereby understand what it means for citizens enrolled in these welfare institutions.

**Holistic interventions: formulating identities**

The two interventions in focus are offered in different settings. One intervention is offered in remand prison, the other in the community. In compliance with the Law on Social Services, the prison-based intervention describes itself as having a “holistic approach”, for example in their accreditation report where they stress that the intervention is “holistic as well as differentiated according to the needs of the individual participants” (Accreditation Report, 2009, p. 7). The community-based intervention offers a variety of services aimed at the “social inclusion” of marginalised people (including drug-experienced youth in contact with the CJS). Similar to the prison-based intervention, they state explicitly that they have a “holistic approach”, for example in working with citizens who are in need of assistance to navigate the “complex public welfare system” and in the ambition of constructing “coherence” between the different systems a citizen is enrolled in (Community based intervention, 2016). In other words, both interventions follow legal demands and/or adopt social work perspectives referred to as a “holistic approach”, and both interventions refer to a “holistic approach” as a particular way of understanding and approaching citizens with complex problems, i.e. citizens seeking help to solve multiple problems. First, this implies that none of these interventions approaches a particular problem “in isolation” (for example drug use), but instead is related to other challenges that the young person might have, and therefore also their wider everyday life (including for example offending behaviour, mental health problems, living in deprived areas, having a troubled family background). Drug use is therefore approached together with and in relation to the other problem(s) that the citizen might face, and it is recognised that helping the citizen with other aspects of their life can have a positive effect on reducing or ending drug use. Second, both interventions aim to approach and construct solutions to these multiple problems by establishing inter-sectorial co-operation between, for example, the Prison Service, municipal drug treatment, social benefit services, educational institutions and to make these systems co-operate in order to help their young participants.
Formulating institutional identities

Welfare institutions are in general characterised by offering particular solutions to particular problems (e.g. Jöhncke et al., 2004), and therefore also by engaging in the construction of particular problem understandings, often (but not only) in relation to citizens who are seen as “problematic” or “distressed”, for example due to drug use, unemployment, or homelessness (e.g. Järvinen and Mik-Meyer, 2003, 2012). Thus, to become enroled as clients in a welfare institution, citizens in need of help have to subject themselves to the understandings and solutions that welfare institutions offer, and as part of this to take on “the identities that the institutions formulate and promote” (Gubrium and Holstein, 2001, p. 11). As this indicates, one line of welfare institutional research has focussed, precisely, on how welfare services are not merely neutral “problem solvers” but also how they, as part of addressing the issues which the citizens need help to handle, are constructing “institutional identities” for their clients (e.g. Gubrium and Holstein, 2001; Järvinen and Mik-Meyer, 2003; Järvinen and Gubrium, 2016). These institutional identities emerge through subjectification processes that play out between the norms, values and organisational structures that shape how (welfare) institutions define and solve the problems they aim at, and the biographical particulars and specific social conditions of the citizen (Gubrium and Holstein, 2001). “Who one is”, in other words, becomes a public concern, and “the self” a social structure which is constantly constructed in and through the different discursive environments of everyday life. This includes, but is not restricted to, the various (welfare) institutional settings, which for example drug experienced youth in contact with the CJS are subjected to. However, as Gubrium and Holstein (2001) note, “the possibilities for who we might be as troubled persons are not set in stone, but vary across time and social circumstance” (p. 14). As such, the same person may be identified differently in different welfare institutions.

Another, but related, line of welfare institutional research which is relevant for our analysis focusses particularly on citizens who embody a variety of problems, and who, because of this, are simultaneously enroled in several services, such as for example drug treatment (because of drug problems), psychiatric treatment (because of psychiatric problems), and prison services (because of offending behaviour). A specific mode of interest in this line of research revolves around the observation that welfare services often have difficulties with handling such “complex problems”, and, moreover, that the problem understandings and solutions of these various services do not necessarily match (e.g. Nygaard-Christensen et al., 2018; Bjerge et al., 2018; Johansen, 2018). So, despite the fact that welfare institutions in Denmark, on a national level, answer to the same laws and policies, for example by being obliged to provide “holistic” solutions to citizens with social problems, varying institutional “set ups” mean that these solutions are possibly enacted in a variety of ways (cf. Lipsky, 1980). Such variations, for example in the form of organisational structure, institutional values and wider institutional embedding, enable different – and not necessarily congruent – “institutional identities” for their clients.

Taken together, in relation to our analysis of welfare institutional enactments of “holistic approaches” aimed at drug experienced youth in contact with the CJS, these perspectives enable us to explore how a prison-based intervention and a community-based intervention – both approaching their clients by means of “holistic” efforts – in practice formulate quite different identities for their clients. It is the emergence of these institutionally constituted identities that we wish to explore in our analysis, in order to be able to discuss their implications in relation to drug use prevention for young people in contact with the CJS. Following Gubrium and Holstein (2001), we will pay analytical attention to what is locally available in the two interventions in terms of identity resources (e.g. problem understandings; organisational barriers); however, in this paper we will not focus on how processes of self-construction then unfold among the clients of these institutions. Our aim here is merely to highlight the contours of available identities within the discursive environments that define our two chosen interventions, whilst the particulars of how these institutional identities are “put into practice” by the young participants is left for later analysis (cf. Gubrium and Holstein, 2001, p. 16).

Before presenting our analysis, we will first describe our methods and data in more detail.

Data and methods

The two interventions under scrutiny here accommodate drug experienced young people, who due to different forms of offending are presently in contact with the Danish CJS, either because they are in
Our analysis of what identity resources are locally available in the two interventions is based empirically on publicly available written material from these two interventions, as well as qualitative interviews with professionals working in these interventions. This empirical combination enables a top-down analytical focus on purposes and aims of the interventions on a local level; how these purposes and aims are related to wider, national policies around services aimed at citizens with “complex problems”; and finally – particularly by means of interviews with professionals – an insight as to how official purposes and aims are enacted “on the ground”. Written material includes formal descriptions of the interventions, stemming from evaluation reports, brochures, newspaper articles and webpages. We interviewed nine professionals in all. Interviews are semi-structured individual interviews with five professionals and two interviews with two professionals at the same time (i.e. four professionals). Three individual interviews were made with professionals from the prison-based intervention and two individual interviews with professionals from the community-based intervention. We used a semi-structured interview guide focusing on different themes, including professionals’ perceptions of the intervention in focus; the role of quality standards in the intervention; and perceptions of drug use trajectories among their young clients. All individual interviews were recorded and transcribed verbatim. The two interviews in which we interviewed two professionals together were not recorded, but two of the authors were present in the interview situation, and extensive notes were taken during the sessions. All professionals were practitioners working on a daily basis with the young adults. They have various social pedagogical and therapeutic backgrounds and training, and several years of experience in working with young people in drug-reducing interventions. In the prison- and community-based interventions, there were six and eight employers professionals, respectively. In both interventions there were other kinds of professionals as well, e.g. staff. We only interviewed employed professionals. We recruited interviewees with different backgrounds and experiences in order to secure different perspectives and experiences from the two interventions. All professionals signed informed consent forms and all professionals are anonymised[5]. For anonymity purposes, we refer to professionals with a number in the analysis, e.g. “professional 1”, and we refer to all as “s/he” or “they”. All transcribed interviews were coded using NVivo11. For the present article we used the codes “holistic approach”, “co-operation” and “problem understanding (of the client)”. We incorporated the extensive notes from the two interviews where two professionals were interviewed together.

Analysis

In the analysis we focus on the following issues: drug use and how this “problem” is understood as part of a broader nexus of “complex problems” in the two interventions (problem understanding);
the solutions to this issue, particularly in the form of inter-sectorial co-operation practised in the interventions; and the barriers that the interventions are faced with in terms of delivering “a holistic approach”. Throughout the three sections we include analyses of how these issues have an effect on the formulation of the “institutional identities” that are constructed in the interventions.

Young people with complex problems

Professionals interviewed from the two interventions have a similar understanding of the young people they are working with: they are young people with complex problems who do not fit into existing welfare institutions. Professional 1 from the community-based intervention for example says:

The citizens who come here are so different that it is hard to put them in a particular pigeonhole. They do not match the categories that exist in the public services.

While this is the general point of departure for the community-based intervention, the aim of the prison-based intervention is, in particular, to address drug use and offending behaviour. Despite this, professionals in the prison-based intervention, too, understand their participants as young people with complex problems. They see them as young people who do not follow the expected developmental pathways, for example in terms of obtaining an education:

[...] they are in an extremely stressful situation, and under pressure [...] but they also deal with a lot of different things. For example, having left school too early and not finished with an exam. They are very young when we see them here in our intervention, 18, 19, or 20 years old (Professional 3, Prison-based intervention)

Professionals in this intervention emphasise that drug use is not a delineated issue, but part of a more complex nexus of problems such as offending behaviour, damaged social and family relationships, and their general everyday milieu, as for example being on social security, being homeless and having broken educational trajectories:

I definitely view drug misuse as a symptom of their problems. It might not always be the case, but it usually is. Those who are easiest to help are those who do not carry a big load of other issues [...] They are not as fixed in their habits and ways of life. I often think of drug misuse as a symptom, but with a persistent negative effect (Professional 1, Prison-based intervention).

Thus drug use is seen as intrinsically related to the often deprived backgrounds of their clients. It is a symptom of “deeper” problems, yet as an unfortunate way to handle them, which has, or will, become problematic in itself. In accordance with this problem understanding, professionals in the prison-based intervention – if this fits the young participant’s wishes – seek to focus broadly on their life situation, and not merely on their use of drugs.

In addition to having similar views on the complexity that marks their participants’ situations, professionals in both interventions share the understanding that the Danish welfare system is too difficult to navigate for their young participants, and that they, as professionals who work with this particularly “system-vulnerable” group of young people, therefore need to assist them on this matter:

One thing is that they have to show up in drug treatment alone, which for some can be quite overwhelming. And if they, on top of this, experience that when they actually do show up, they are not getting the help that they need, and maybe they are put on hold [...] then it’s easily like, “bye bye, I’ll handle these things on my own”, right. This is often what we hear when we follow up on our participants who are released to freedom (Professional 2, Prison based intervention).

Professionals in the community-based intervention describe similar experiences of “the system’s” complexity which make it difficult for their young participants to get the help that they need, and emphasise that changes in who the young person is in contact with when attending the municipal social services create frustrations:

I hear often that the young people for example get a new social worker, that they then have to start over again, and that the social worker has not read our young person’s file. What they also say with these experiences is that they do not feel that they are taken seriously or that they simply feel neglected – “the social worker did not understand what I said” or “she didn’t care at all about me” (Professional 2, Community-based intervention).
To sum up, both interventions have very similar problem understandings vis-à-vis the young people they are working with. They see them as young people with complex problems, who are easily lost in the complexity of the welfare system, and, following from this, that a “holistic approach” with a main focus on inter-sectorial co-operation is an important part of the solution to their problems. On this “ideological” level, then, the institutional identities, which are constructed, revolve partly around issues of “vulnerability” in the sense that these are young people who are not only seen as vulnerable in terms of drug use and other forms of “problem behaviour”, but also in terms of not getting the help that “the system” is obliged to provide. But, at the same time, due to the “holistic” ambition of including participants’ own perspectives, they also become subjected to the notion that they are “experts” – not in “system navigation”, but on their own needs (cf. Frank and Bjerge, 2011). In spite of these similarities, however, the two interventions enact “a holistic approach” through inter-sectorial co-operation in very different ways, particularly due to organisational circumstances. As we will show in the following, this results in constructions of very different institutional identities.

Enactments of inter-sectorial co-operation

Starting with the prison-based intervention, professionals here focus on how they can establish contact with other relevant welfare services in their participants’ home municipality, or, alternatively, with interventions in other prison institutions, if the young person is transferred after their sentence is passed:

Everytime a participant is transferred I contact the drug treatment intervention – either in another prison or in the community. In the community, it is more difficult. We give the contact details to the participant and often call to see whether he showed up. Occasionally, we also help set up a meeting. But it is up to the young person to get in contact with the particular service if he wants to continue in drug treatment (Professional 2, Prison based intervention).

Professionals thus describe how making connections for their client to other drug-treatment institutions is a central aspect of their work. In these cases, they seek to co-operate with other welfare services that the young person would possibly benefit from being enrolled in. Importantly, however, this is done on behalf of the young person – and not, as we shall see with the community-based intervention, together with them. As professional 1 in the prison-based intervention states: “It is our job to give them contact details, help them knowing where to go […] but we can only be the link”. Thus, in this intervention, the professionals make the phone calls and write the e-mails, or in other ways line up welfare institutional possibilities for their young participants to take up later on. As such, professionals in the prison-based intervention create “links”, “paths” and “build bridges”. However, due to the circumstance that this intervention is located in a prison setting, the young person is “stuck” in his cell while these future-oriented processes take place. Nonetheless, it becomes his responsibility to follow the paths which were laid out for him upon release or transfer. Arguably then, in addition to being subjected to mixed notions of “vulnerability” and “expert” on a “holistic-ideological level”, the prison-based intervention’s participants are furthermore subjected as “non-active” on a “holistic-enacted” level. The professionals act on behalf of them. This, however, is at least to some extent because this intervention is firmly bound by the circumstance that, while being in drug-pre-treatment, their participants are unavoidably also prisoners. Consequently, the “institutional identities” which are formulated for these young people with complex problems are arguably multi-dimensional. They become both a mix of “vulnerable” and “experts” (vis-à-vis the ideal interpretation of “a holistic approach”) but also, and at the same time, “non-active”, but still expected to act as an empowered citizen who is able to follow these laid out paths upon release or transfer (vis-à-vis how the “holistic approach” is actually enacted). The solution (inter-sectoral co-operation) to the problem (complex problems, including drug use) is thus far from straightforward. Importantly, this added complexity in terms of enacting a holistic approach in a remand prison does not stem from un-engaged or un-skilled professionals, but from the fact that this intervention is both bound to, restrained by, and exists due to the prison system.

Even though the community-based intervention has a broad target group (marginalised citizens in need of help) as compared with the prison-based intervention, their participants are primarily young people with complex problems, including simultaneous drug use and offending behaviour.
Thus, already prior to their participation in this intervention, participants are subjected to multiple institutional identities formulated by the different institutions that they take part in. One of the community-based intervention’s main priorities is exactly to assist their young participants in navigating in and between these institutions, their rules, regulations and (identity related) requirements. As such, this intervention, on an institutional level, positions itself, not as an “integrated part” of the Danish welfare system, but as being somewhat in opposition to the established system, albeit with enough know-how and insight to assist their participants in becoming knowledgeable about this system themselves. In the community-based intervention, inter-sectoral co-operation is thus enacted quite differently than in the prison-based intervention. Overall, professionals in this intervention do this by “walking the steps together with” the young person:

We simply start by asking what the user dreams of. What is it he or she wants? Whatever it is – contact with the system, getting different systems to talk to each other, or get a doctor’s appointment – we start there. We help the citizens to walk the steps, make the phone calls, and set up a meeting with the social worker or the doctor, or set up a network meeting with relevant professionals from different systems. Get a good co-operation going, and help our participant to get on from there. This can be quite overwhelming if you are a citizen in a vulnerable situation [...]. We don’t do it for them, but walk the steps together with them. One day they will be able to do it themselves (Professional 1, Community-based intervention).

Professionals in this intervention thus organise, set up and accompany their participants to meetings and appointments, whether they have been summoned to a meeting, for example in the Prison Service, or they voluntarily want to get in contact, for example, with social services, the psychiatric system or an educational institution. This enactment is, at least partly, informed by the knowledge that many of their participants have experienced a great deal of difficulty with not being met by “the system” in a proper way when they seek contact on their own, experiences of being turned down or denied help, and that they therefore “hate” the system. Professionals seek to assist the young person to engage with the system in a way that is helpful for them:

We begin, because we know it is very difficult for them to pick up the phone. One client has experienced, again and again, not being able to get through to the right person. Then we are her representative (Professionals 1, Community-based intervention).

As such, professionals in this intervention become “representatives” or “mentors” for the young person. They aim to “navigate the system” together with them and to “teach them how to manage or handle how the system is structured”:

I often think of our job as a translation job. We are clearly on the citizen’s side, but try to translate what the reason for e.g. not getting a service is. That it is about resources or that our user does not fit the target group of a certain intervention. If it is explained properly, we often experience that the user accepts this. Especially if it is about economic resources. Translating between the system and our users can avoid a lot of conflicts between the user and the system (Professionals 1, Community-based intervention).

The professionals thus support the process of “making things happen” by engaging in such things together with them, by supporting them with their presence whenever needed, and as such the professionals scaffold the client’s way around the system. For good reasons, since this is a community-based intervention, the professionals are able to accompany their participants to other services. In terms of institutional identities, the young participants in these contexts thus become an “apprentice” or a “mentee” who is obliged to “learn” from the professionals, i.e. how to navigate in the different welfare systems. They are required to be actively engaged in their own process, and as part of this, required to learn about how the welfare system works, how it is organised, and how best to accommodate to it.

To sum up, while the two interventions share common ground on an ideological level particularly in terms of how they portray their young participants as, at the same time, “vulnerable”, “experts” on their own situations, and in need of inter-sectorial help, they do also differ. As we have aimed to show, differences are, at least partly, based on the fact that the interventions are embedded very differently, both in relation to the wider Danish welfare institutional landscape and in terms of internal organisation and structure. Whilst the prison-based intervention must submit to the Prison System’s rules and regulations, which then affect the institutional identities they come to formulate for their clients, the community-based intervention is able to engage their participants and teach them how to get the help they need. In consequence, the prison-based intervention is obliged to act on behalf of the young
person as part of their inter-sectorial efforts, while the community-based intervention is able to act together with their participants. As we have argued, these organisational differences hence enable rather different institutional identities. Enacting a holistic approach within a remand prison simply gives professionals very different possibilities, and serves a different purpose, to working in the community. This, however, does not mean that the professionals in the community-based institution are not faced by any challenges or barriers when doing their job – challenges which also affect how institutional identities are formulated. In the final analytical section, we will focus particularly on structural barriers, and what they consist of in each of the two interventions.

**Structural barriers**

Professionals in both interventions experience structural barriers in their processes of enacting a “holistic approach”. As suggested above, in the prison-based intervention structural barriers are predominantly related to their embeddedness in the Prison Service, primarily that they are obliged to submit to overall prison rules and regulations, for example that participants are regularly transferred without notice. Consequently, the prison-based intervention’s aim of creating pathways to drug treatment in other prison settings through co-operation and knowledge exchange is easily compromised:

Many of the drug treatment offers in prisons have long waiting lists. So, a young person can be transferred from here to a prison, but cannot enter drug treatment before there is a vacant place. Also, sometimes they are not transferred to the prison with the drug treatment offer that would suit them best. Safety and filling up places in prisons take priority (Professional 1, Prison-based intervention).

In addition to internal structural barriers, the prison-based intervention is dealing with barriers that emerge between themselves, i.e. a prison-based drug intervention, and municipal or private interventions located in the community. This gap becomes a significant structural barrier particularly when professionals seek to construct and support their participant’s future treatment participation through inter-sectorial co-operation with partners outside the prison setting. It is, in other words, difficult to build and maintain a preferred level of co-operation between the “closed prison world and the world outside”, as professional 2 says:

We simply have a challenge in terms of getting them [municipal treatment providers] to come in here for meetings, and to make them trust our assessments of our participants. They want to make their own visitations/assessments in order to evaluate whether they are entitled to treatment despite that we know they are […] Sometimes it feels like we lose our participants in the process. […] It is in the translation it gets difficult, even if they become drug free in here.

As the quote exemplifies, “bridge-building” between the prison and the community setting as part of securing continuation of help for a participant can be highly complicated. First, because meetings with contact persons from community services can be difficult to establish, which means that the young participant does not get to know these professionals, and vice-versa. Second, because some of these welfare services, here exemplified by community drug treatment, are not comfortable with the intervention’s assessments, but want to make their own. Arguably, this results in a sense of “institution-level stigma”, which might possibly strengthen the marginalisation that already marks the young people who the prison based intervention is accommodating, for one thing, because it complicates further the already complicated process of securing them the help they need. Another, and similar, structural barrier described by the prison-based intervention is that remand prisoners are put on “standby”, not only in terms of being “stuck” in their cells, but also by the municipality, as suggested in the quote below. This situation also poses problems for the professionals’ inter-sectorial efforts. Professional 1 explains:

When I am dealing with a participant who will be homeless after release, I have to refer them to a youth-shelter. This is the only way to ensure them a place to be after release, as they are not allowed to be on a housing waiting list while they are in here [prison]. The system simply won’t deal with them before they are contributing actively to society again. So, in order to handle this situation, I refer them to a youth-shelter […]

And continues:

So, when I refer them to a youth-shelter, I can also phone the municipal social worker and say “hey, try and phone the shelter, he is probably there” and then the contact is made.
This exemplifies how professionals are often not able to initiate the support that they know would benefit their participants most. Instead, they have to make alternatives by finding the right "loopholes" in the system (cf. e.g. Lipsky, 1980; Nygaard-Christensen et al., 2018).

Together, the above examples arguably show that the aims of the prison-based intervention of creating "pathways" for their young person to follow upon release or transfer are easily disrupted by a variety of structural barriers which in most cases are related to the fact that this is a prison-based initiative. Importantly, this does not mean that the intervention is ineffective or redundant. On the contrary, as we see it, it stresses the importance of their existence while also informing us about the manifold difficulties that emerge when systems’ values and norms collide. As part of this, what, from a social work perspective, serves these young people best is very easily thwarted by the hierarchical relationship that exists between this initiative and the correctional purposes of the prison service, and which, in terms of prevention of future “problematic behaviour” (drug use, offending), may even be counterproductive (cf. Christiansen, 2018).

Shifting focus to the community-based intervention, an important structural barrier experienced by the professionals in enactments of inter-sectoral co-operation by “walking the steps together with the client” relates to the fact that different welfare systems have different rules and policies. The inconsistencies that emerge from this are often difficult for young people who are simultaneously enrolled in different welfare institutions. For example, if a young person is on parole with an electronic tag, this means that s/he has to be drug free and deliver negative urine tests. However, this does not necessarily comply with the norms of the drug treatment that the young person might also be enrolled in, in so far as reduction of drug use and harm reduction is the focus:

They are tough in the Prison Service. He is on parole with an electronic tag. He got a chance to serve his sentence on milder conditions. But this means no drugs and negative urine tests. If not, he will be sent back in prison. But they don’t ask why he uses drugs. [as is the case in drug treatment]. They don’t focus on co-operating with us, for example, or with the drug treatment services. When he got the electronic tag off, he was back on drugs. So, we see it as our job to facilitate cooperation between drug treatment services, the Prison service and the young person (Professional 1, Community-based intervention).

In this example, the professional points to differences in norms, values and rules in different welfare systems, but also to how Prison Service rules (always) takes precedence over other welfare services’ way of dealing with these young people (cf. Frank and Kolind, 2008). Thus, as is also the case for professionals in the prison-based intervention, professionals in the community-based intervention must struggle to knit together the best possible co-operation between welfare services. The experience of navigating between several sets of norms and values, especially when one takes priority over the others (here exemplified with the Prison Service’s culture and regulations around security, order, zero-tolerance and sanctions), is also discussed in both national and international literature (see, e.g. Goldhill, 2016; Frank and Kolind, 2008).

Another example of how barriers to inter-sectoral co-operation emerge from inconsistent problem understandings between two (or more) welfare institutions, is described by professional 2, when s/he talks about working with young participants, who are enrolled in both the psychiatric system and in community drug treatment:

I am a lay representative for a young person who needs assessment at the psychiatric hospital. The young person also has a problematic use of drugs. Then the psychiatric hospital will not assess him and he cannot get psychiatric treatment. They say: “stop your drug misuse and then you are welcome here again”. The young person “falls between two stools”. It makes me angry. It is not possible for these young people to take one thing at a time: first get out of drug misuse, then be treated for ADHD, borderline or anti-social behaviour. These things will always overlap. And we haven’t even talked about offending behaviour and being in contact with the criminal justice system yet.

The quotation emphasises how the solution to a problem can only be implemented under particular circumstances, or more specifically that psychiatric treatment can only be offered to young people without an ongoing use of drugs. These barriers are not only experienced by professionals in the community-based intervention, but are a general challenge for many professionals, as for example Johansen (2018) emphasises. But particularly in the context of our intervention, this pattern means that the ambition of teaching their participants how to navigate between different “institutional identities” becomes unachievable – simply because the inconsistencies, in some cases, seem impassable.
Conclusion: implications for prevention?

Our aim with this paper has been to discuss how a “holistic approach” is enacted in two interventions accommodating the same target group, young adults with offending behaviour and drug use, but offered in very different contexts, the Prison Service and the community. Our ambition has been to show how enactments of a “holistic approach”, although similar on paper, differ in welfare institutional practice due especially to organisational and structural conditions. Our argument has been that different enactments of a “holistic approach” construct different possibilities for institutional identities. These insights, we will argue, could be useful to take into consideration when discussing prevention initiatives (in a broad sense) for young people with complex problems, including co-occurring offending and drug use.

Both interventions under scrutiny in this paper are unique compared to other welfare interventions offered in prisons and in the community to young adults in Denmark. While there are pre-treatment offers in other remand prisons in Denmark, none is as elaborate as the one presented here. The community-based intervention is unique in accommodating all marginalised citizens in need of help (not focussing on a particular “problem”, e.g. drug use or homelessness), and also in performing lay representative work for their participants. The two interventions in focus are therefore “innovative” rather than “standard” cases of what else is offered to this target group in Denmark. However, in terms of establishing new and different initiatives targeting this group of young people, it is in any case important to keep in mind the conditions and circumstances within which such interventions are operating. While it is valuable to implement “holistic approaches” when dealing with this target group, it is, at the same time, necessary not only to focus on policy and social work ideas but also on the extent to which they are possible to enact in differently organised and institutionally embedded welfare institutions.

In the analysis we have shown how the two interventions in focus here have similar problem understandings, their participants being young adults with complex or multiple problems who do not fit into one welfare institution, but are or should preferably be enrolled in several institutions in order to get the help that they need. The interventions also share the notion that the Danish welfare system forms a complex landscape that can be difficult to navigate, and that the young people therefore easily become “system-vulnerable”. Consequently, facilitation of inter-sectoral co-operation serves as an important technique in how these interventions enact a “holistic approach”. Furthermore, we have argued that a “holistic approach” is considered to be important, both in Danish welfare policy and in the social work literature. As such, a holistic approach is “in vogue” and recommended from many sides, including international research literature (e.g. Menon and Cheung, 2018). However, our data also suggest that what seems a sensible and recommended idea might not necessarily be an easy task to implement “on the ground”. Due to organisational structures, institutional values and wider institutional embedding, professionals have particular constraints when enacting a “holistic approach”.

Notes

1. The article is part of the project 768162/EPPIC, which has received funding from the European Union’s Health Programme (2014–2020). The content of this report represents the views of the authors only and is their sole responsibility; it should not be considered to reflect the views of the European Commission.
and/or the Consumers, Health, Agriculture and Food Executive Agency or any other body of the European Union. The European Commission and the Agency do not accept any responsibility for use that may be made of the information it contains. See also www.eppic-project.eu

2. See Frank and Bjerge (2011) for further information on user involvement in social welfare services in Denmark.

3. The quality standards include for example the use of evidence-based methods, monitoring and annual evaluation of whether the intervention has reached its goals.

4. For detailed descriptions of the two interventions see Herold and Frank (2018).

5. The research project has been approved by the Danish Data Protection Agency.

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Further reading


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Underage drinking as a natural part of growing up: a UK study of parental beliefs

Emily Fulton, Darrin Baines and Naomi Bartle

Abstract

Purpose – Parental beliefs about underage drinking are known to influence the drinking behaviours of their children. The purpose of this paper is to explore parental beliefs about their own child drinking alcohol and young people in general, in order to ascertain whether there is a need to target such beliefs in the design of public health interventions.

Design/methodology/approach – Parents of 11–18 year olds attending one of nine schools in the Midlands of England, UK were invited to take part. Participants completed a newly designed 40-item questionnaire measuring parental beliefs about the impact and causes of underage drinking; talking to their child about alcohol; and how much and how often they thought their child consumed alcohol.

Findings – In total, 185 parents took part in the study, reporting on their eldest child aged 18 or under. The majority of parents agreed that underage drinking is detrimental to child health and wellbeing. However, over 60 per cent believed that alcohol consumption is a “natural part of growing up”, and stronger agreement with this belief was associated with higher parental reports of alcohol consumption in their children.

Social implications – The majority of parents recognised the risks and negative effects of alcohol; however, many also believe it is a natural part of growing up. Parents may hold conflicting beliefs about underage drinking, which could impact on the drinking beliefs and behaviours of their children.

Originality/value – Public health interventions may need to counter the common parental belief that underage drinking is a normal part of growing up, and stronger agreement with this belief was associated with higher parental reports of alcohol consumption in their children.

Keywords Adolescents, Young people, Children

Paper type Research paper

Introduction

The prevalence of drinking under the legal age of 18 years remains high in the UK (Healey et al., 2014). Adolescent alcohol use has been linked to poor physical and mental health including depression (Edwards et al., 2014), suicide (Bagge and Sher, 2008), poor sexual health (Vazsonyi et al., 2006) and a negative impact on brain development (Monti et al., 2005). The impact on education and family life can also be significant (Anderson and Baumberg, 2006). Children’s drinking behaviours are influenced by many factors including the beliefs and behaviours of their peers (Kristjansson et al., 2010) and messages in the media (Grube and Waiters, 2005). The beliefs and behaviours of parents are known to influence the drinking behaviours of their children in direct and indirect ways. This includes the monitoring of child alcohol intake, restricting availability of alcohol, setting rules in the home, parent–child communication and modelling “acceptable” drinking behaviour (Mynttinen et al., 2017; Palmer and O’Reilly, 2008; Livingston et al., 2010; Koutakis et al., 2008). Parental disapproval of alcohol intake is associated with less adolescent alcohol intake (Nash et al., 2005); and this effect occurs regardless of parent and peer drinking behaviour (Çözdemir and Koutakis, 2016). However, research exploring permissive parental attitudes is contradictory. Some studies found that a more lenient parental attitude to drinking is associated with more excessive adolescent drinking (Mares et al., 2011), whereas a systematic review and meta-analysis of 13 studies found no effect of parental permissiveness on alcohol-related problems in...
later adolescence (Sharmin et al., 2017); although risk of bias was highlighted. If parental attitudes influence child drinking behaviour, then to influence these attitudes, there is first a need to understand parental beliefs about underage drinking and their child drinking alcohol. This is in light of theoretical models of behaviour which posit that beliefs shape attitude formation (e.g. “The theory of planned behaviour”; Ajzen, 1991). To the author’s knowledge, there is limited evidence in the UK literature focusing specifically on parental beliefs. Consequently, the main rationale of this study was to measure parental beliefs and whether relationships exist between these beliefs and parental reports of how much and how often they believe their children consume alcohol. It was intended that the findings would identify potential parental beliefs to target within public health interventions.

Methods

Procedure

Parents of children aged 11–18 years from 1 of 14 schools or colleges in the Solihull region of the West Midlands, UK, were invited to take part. Schools were initially contacted via e-mail from staff in the local authority Public Health Department, on behalf of the researchers, using existing links with all schools in the locality. Ethical approval was obtained from Coventry University Ethics Committee. In each participating school, parents were sent a link to a secure online questionnaire via the standard school e-newsletter. The questionnaire included an information sheet and the requirement to register participant consent before taking part in the research. Either mothers or fathers were invited to contribute. Both could participate collectively as part of a single submission if they wished. Where family viewpoints differed, parents were asked to provide a compromised response. Parents were asked to provide one response per household, and to comment on one child (their eldest under 18 years old) only. This was in light of the fact that statistical analysis relied on the assumption that all cases are independent, which some may not have been had two responses been supplied from either parent, for the same child. Parents were reminded throughout that their responses regarding their beliefs about their child and young people’s drinking referred to underage drinking in the 11–18 years age group only.

Measures

The anonymous online questionnaire included 31 items. This consisted of 7 demographic questions, level of agreement (strongly agree to strongly disagree) with 19 parental beliefs items about why young people drink and the impact; 2 items about how much/often they thought their child drank; 2 items about children drinking under supervision in and out of the home; and a single item about whether they talked to their child recently about alcohol. The questionnaire was designed with input from public health practitioners and commissioners, health psychologists and parents, and was also based on a review of existing measures of attitudes to underage drinking and consumption (quantity/frequency) (e.g. Engels et al., 2007) that were also designed de novo. It was piloted with a group of parents (four mums and two dads) who were contacted via existing local public health social media channels; and feedback was sought regarding content, the number of items, scoring and ease of comprehension. The questionnaire was then revised accordingly having recognised that some items were perceived as confusing or ambiguous. For example, clarification was requested about whether parents were reporting on young people in general or their own children. As the measure had not been used before, the psychometric properties were not known. Response options included five-point ordinal Likert scales to report the frequency and amount they thought their child drank (never drinks alcohol; occasionally drinks alcohol (e.g. once a month or a few times a year); once or twice a week; several times a week; and daily); and agreement with statements regarding the causes and impact of drinking on young people (on a five-point scale from strongly agree to strongly disagree). The Likert scale was adapted from existing measures of amount/frequency (Livingston et al., 2010; Engels and Knibbe, 2000), to align with the commissioning Public Health Department’s classifications. The amount of alcohol consumed was measured in number of drinks consumed as per similar studies (e.g. Engels et al., 2007), as the pilot study indicated that parents struggled to understand and accurately calculate units.
Statistical analysis

Data were analysed using the Statistical Package for the Social Sciences. As a lack of normality in the data was evident from inspection of the histograms, non-parametric tests and “bootstrapping” were applied to the analyses to address this. Spearman’s rank correlation was used to ascertain relationships between beliefs and reports of how often and how much parents thought their child drank alcohol. The Mann–Whitney U test was used to compare groups including younger parents (25–44 years) and older parents (45–64 years) and parental responses for younger children (11–14 years) and older children (15–18 years). Where correlations between parental beliefs and alcohol consumption outcomes were significant ($p < 0.05$) with both dependent variables they were included in bootstrapped regression analyses to explain reports of how much and how often their child drank alcohol.

Results

In total, 9 of the 14 schools invited agreed to take part. Invites to participate were sent to approximately 5,097 families, and 185 families took part in the study, giving a response rate of only approximately 3.6 per cent. It was not possible to ascertain information about the non-responders as consent was not obtained. The “Index of Multiple Deprivation” calculator indicated a relatively even spread of more and less deprived schools within the sample, despite the fact the locality as a whole is from a more affluent part of the UK. There were no clear differences in terms of geographical location and related socio-economic status between the schools who agreed to take part and those who did not. Therefore there was a reasonable representation across levels of deprivation, although some caution should be given in terms of generalisation.

The majority of respondents were mothers (89 per cent), and described themselves as of white British ethnicity (81 per cent). More respondents were reporting on younger (11–14 years) than older children (15–18 years) (see Table I). There was no difference in reporting between male and female children (51.6 per cent male). Where parents “agreed” or “strongly agreed” with an item on the questionnaire, the percentages are combined to indicate general agreement (“agreed”) in the following results.

Parental reports of their child’s alcohol consumption

When asked about frequency of consumption, 39.5 per cent of parents reported that their child had ever drunk alcohol and less than 20 per cent of parents thought their child consumed alcohol.

<table>
<thead>
<tr>
<th>Table I</th>
<th>Parental reported frequency and amount of child’s alcohol consumption</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response option</td>
<td>% total sample ($n = 185$)</td>
</tr>
<tr>
<td>Frequency of alcohol consumption</td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>60</td>
</tr>
<tr>
<td>Occasionally</td>
<td>31.9</td>
</tr>
<tr>
<td>Once or twice a week</td>
<td>5.4</td>
</tr>
<tr>
<td>Several times a week</td>
<td>2.2</td>
</tr>
<tr>
<td>Bingeing pattern</td>
<td>0</td>
</tr>
<tr>
<td>Do not know</td>
<td>0</td>
</tr>
<tr>
<td>Missing</td>
<td>0.5</td>
</tr>
<tr>
<td>Number of alcoholic drinks consumed per week</td>
<td></td>
</tr>
<tr>
<td>No alcohol</td>
<td>81.6</td>
</tr>
<tr>
<td>1 or 2 drinks</td>
<td>10.8</td>
</tr>
<tr>
<td>3 or 4 drinks</td>
<td>2.2</td>
</tr>
<tr>
<td>5 or 6 drinks</td>
<td>1.1</td>
</tr>
<tr>
<td>More than 6 drinks</td>
<td>2.2</td>
</tr>
<tr>
<td>Do not know</td>
<td>0</td>
</tr>
<tr>
<td>Missing</td>
<td>2.2</td>
</tr>
</tbody>
</table>

Notes: *For example, once a month or a few times a year; *for example, six or more standard drinks in one occasion or heavy drinking for days or weeks followed by no drinking for days or weeks (based on local Public Health Department definition)
at least weekly. Table I shows the breakdown of these findings. Older parents (45–64 years of age) reported that their child drank significantly more often ($Z = −2.877, n_1 = 86, n_2 = 98, p = 0.004$) and in greater amounts ($Z = −2.794, n_1 = 83, n_2 = 98, p = 0.005$) than younger parents (25–44 years of age). There were no significant differences between older and younger parents in terms of: their attitudes and beliefs about their child’s drinking; underage drinking in general; and when they last talked to their child about alcohol. No significant differences were found between parents of younger children (11–14 years) and parents of older children (15–18 years) in reporting of how much ($Z = −0.400, n_1 = 107, n_2 = 68, p = 0.689$) and how often their child drank alcohol ($Z = −0.067, n_1 = 110, n_2 = 69, p = 0.947$) and when they last talked to their child about alcohol ($Z = −0.141, n_1 = 99, n_2 = 63, p = 0.888$).

**Parental beliefs about young people drinking alcohol**

Over 90 per cent of parents believed that young people drink due to peer pressure, wanting to feel part of a group and because they enjoy experimenting. 62.6 per cent of parents agreed that drinking by young people “is a natural part of growing up”. There was a significant positive correlation between parental beliefs that drinking alcohol “is a natural part of growing up” and their reports of how much their child drinks ($r_s = 0.235, p = 0.002$) and how often they drink ($r_s = 0.182, p = 0.017$). There were no other variables that correlated with both outcomes. Other significant correlations between parental beliefs and reported drinking outcomes are reported in Table II, including negative correlations between beliefs that drinking could lead to anti-social behaviour, addiction and experimentation with drugs; and how often they thought their child consumed alcohol.

Most parents agreed that drinking alcohol when young could lead to detrimental outcomes in terms of health, family and society. A summary of the level of agreement in descending order

<table>
<thead>
<tr>
<th>Item on the questionnaire</th>
<th>% of parents who “strongly agreed” or “agreed” % of parents who “strongly agreed” or “agreed”</th>
<th>Spearman’s rank correlation with parental reports of</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reasons why young people drink</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peer pressure</td>
<td>94.1%</td>
<td>0.54</td>
</tr>
<tr>
<td>Young people like experimenting</td>
<td>94%</td>
<td>0.10</td>
</tr>
<tr>
<td>To feel accepted or part of a group</td>
<td>91.8%</td>
<td>0.10</td>
</tr>
<tr>
<td>To feel more grown up</td>
<td>88.9%</td>
<td>0.06</td>
</tr>
<tr>
<td>Young people like to take risks</td>
<td>74%</td>
<td>−0.08</td>
</tr>
<tr>
<td>It is a natural part of growing up</td>
<td>62.6%</td>
<td>0.18**</td>
</tr>
<tr>
<td>For the physical effects of alcohol</td>
<td>61%</td>
<td>0.00</td>
</tr>
<tr>
<td>To block out problems</td>
<td>48%</td>
<td>−0.19*</td>
</tr>
<tr>
<td>Impact of drinking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drinking can lead to unprotected sex, increasing the risk of sexually transmitted infections and pregnancy</td>
<td>97.6%</td>
<td>−0.06</td>
</tr>
<tr>
<td>Drinking can lead to violent behaviour</td>
<td>95.2%</td>
<td>−0.07</td>
</tr>
<tr>
<td>Drinking alcohol increases the risk of a range of serious physical illnesses and accidents</td>
<td>94.1%</td>
<td>−0.12</td>
</tr>
<tr>
<td>Drinking alcohol can cause problems in family relationships</td>
<td>92.3%</td>
<td>−0.18</td>
</tr>
<tr>
<td>Drinking causes anti-social behaviour in young people</td>
<td>91.2%</td>
<td>−0.17*</td>
</tr>
<tr>
<td>Drinking alcohol can lead to addiction and dependency</td>
<td>84.7%</td>
<td>−0.21**</td>
</tr>
<tr>
<td>Drinking is often related to peer pressure and can be associated with bullying and pressure to engage in other risky behaviours</td>
<td>80.6%</td>
<td>−0.07</td>
</tr>
<tr>
<td>Drinking alcohol increases the risk of mental health problems</td>
<td>68.8%</td>
<td>−0.05</td>
</tr>
<tr>
<td>Drinking alcohol might lead to experimentation with other drugs</td>
<td>65.1%</td>
<td>−0.19*</td>
</tr>
<tr>
<td>Drink-driving is a significant risk in this age group</td>
<td>59.7%</td>
<td>−0.06</td>
</tr>
<tr>
<td>Drinking alcohol is associated with criminal activity</td>
<td>53.8%</td>
<td>−0.04</td>
</tr>
</tbody>
</table>

Notes: *$p < 0.05$; **$p < 0.01$
under sub-headings can be also be found in Table II. More than a quarter of parents (30 per cent) were unsure or did not agree that “drinking alcohol increases the risk of mental health problems”. In total, 35 per cent were unsure or did not agree that “drinking alcohol might lead to experimentation with other drugs”.

In all, 61 per cent of parents reported talking with their child about alcohol within the last month and, of those, 20 per cent had done so within the last week. In total, 38.4 per cent of parents had not discussed alcohol with their children for over six months, if at all. In all, 60.1 per cent of parents reported that they felt it was easy to identify when young people are drinking. No correlation was found between how often parents report they talk to their child about alcohol and how much \( r_s = -0.069, p = 0.382 \) and how often they report their child drinks alcohol \( r_s = -0.105, p = 0.182 \).

**Multiple regression**

Bootstrapped multiple regression analyses revealed that parental beliefs about young people’s drinking predicted how often and how much they reported their child drank alcohol. The parental belief that drinking “is a natural part of growing up” was the only belief correlated with both outcome measures, and positively predicted how often and how much parents reported their child drank (see Table III).

**Discussion**

In general, parents reported that their child drank no or minimal alcohol, at most consisting of one or two drinks per week in only 10 per cent of parental reports. Over a quarter of parents were unaware of the relationship that exists between alcohol use and mental health problems, and experimentation with illegal drugs. However, the majority recognised other examples of the negative impact of drinking, and in general appeared to believe that underage drinking was a risk to health. Parents who believed drinking might lead to negative consequences such as anti-social behaviour, addiction and drug use reported that their child drank less alcohol. Research to date suggests that although there is evidence that adolescent alcohol use acts as a gateway to drug use (Kirby and Barry, 2012), this and associations with mental health remain poorly understood. Any associations found appear to be accounted for by covariate factors relating to the individual or family in childhood, rather than a direct causal relationship (Newton-Howes and Boden, 2016; Mohamed and Ajmal, 2015). Therefore, further research is necessary to ascertain whether beliefs about the relationship between alcohol and drugs/mental health should form the focus of public health interventions.

In terms of how much and how often parents reported their child drank, older parents (45–64 years) reported that their child drank more often, and in greater amounts than younger parents (25–44 years). It is possible that this reflects older parents with children over 18 years whose behaviour influences their younger siblings. However, if this was the case it was surprising to note that no significant differences were found when comparing reports for children of younger school age (11–14 years) with older school age (15–18 years).

<table>
<thead>
<tr>
<th>Table III</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bootstrapped regression analysis of parental beliefs on parental reports of how often and how much their child drank alcohol</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DV Student</th>
<th>B</th>
<th>95% CI (B)</th>
<th>Adj. R²</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often child drank</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constant</td>
<td>1.11</td>
<td>0.80</td>
<td>1.44</td>
</tr>
<tr>
<td>Drinking is a natural part of growing up</td>
<td>0.12*</td>
<td>0.02</td>
<td>0.21</td>
</tr>
<tr>
<td>How much child drank</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constant</td>
<td>0.71</td>
<td>0.44</td>
<td>0.92</td>
</tr>
<tr>
<td>Drinking is a natural part of growing up</td>
<td>0.17**</td>
<td>0.08</td>
<td>0.27</td>
</tr>
</tbody>
</table>

**Notes:** Bootstrapping based on 1,000 samples. *p < 0.05; **p < 0.01
The belief that young people drinking alcohol is a “natural part of growing up” was held by almost two-thirds of parents. This belief positively predicted how often and how much parents reported their child drank alcohol. In other words, the more strongly parents believed drinking is a natural part of growing up, the more they reported their child drank. Therefore, holding this belief may be associated with increased alcohol consumption in adolescence. Given that parents tend to underestimate rather than overestimate children’s consumption, and there is a positive correlation between parent and child reports (Livingston et al., 2010), this association may warrant further investigation. However, as actual child reports of their consumption were not measured, any direction of causality is unclear. Knowing that your child drinks alcohol may result in parents reporting a belief that this is a normal part of growing up, in order to justify their child’s behaviour, and their role in “allowing” this.

The belief that drinking alcohol when young is damaging and can have a negative impact on many areas of life is somewhat contrary to the belief that it is a normal part of growing up, yet many parents seem to hold these two views simultaneously. One possible explanation is that parents hold both public “outfacing” beliefs and private “inward facing” beliefs (Jayne et al., 2012). Outfacing beliefs are driven by social desirability effects, and therefore may reflect what parents know they should believe from recommended guidance in order to be a “good parent”. In this case, outfacing beliefs may reflect wider society’s concerns about the harmful health effects of underage drinking. Nonetheless, parents may simultaneously hold a private “inward facing” belief that drinking is a natural part of growing up, which may result from their own experience and what they witness other parents condone (social norms). Indeed, Crawford and Novak (2006) argue that parents experience a discord between the desire to keep their children safe from physical harm (health risks of underage drinking) as well as social harm (if they go against societal norm of underage drinking). Parents may experience unease as a result of these conflicting beliefs, also termed “cognitive dissonance” (Festinger, 1957), which describes the psychological state of distress when an individual holds conflicting beliefs. To overcome this, a new belief is formed which allows individuals to hold these contradictory beliefs simultaneously. For example, parents could recognise the potential negative impact, but consider these risks to be rare compared to the high rate of “normal” teenage drinking. This could allow them to condone their child’s drinking due to the belief that their child will only ever experiment at this age (because it is “normal”) and they are unlikely to encounter problems.

Parental approval and permissiveness of alcohol is subject to influence and direction from other parents in their social networks (LaBrie et al., 2011). Indeed, one study found that parents experienced increasing pressures to supply alcohol to their children, as a result of perceptions regarding the social norms of drinking amongst their child’s peers (Gilligan and Kypri, 2012). The “Majority Fallacy” describes the tendency to exaggerate estimations of how much we think peers drink or other parents allow their child to drink in order to validate our own, or our child’s drinking (Makela, 1997). In support of this, recent research demonstrates that adults perceive the wider community as more accepting of underage drinking than they are (Jones and Francis, 2015), further justifying their choices safe in the knowledge they are on the comparatively conservative side. This may allow parents to further increase the normality of their child’s drinking but see the risks as rare and something that will happen to others and not themselves. A longitudinal study of 494 youths and their parents provides further support for this hypothesis since parents who encountered their child drinking tended to adapt their own beliefs regarding youth drinking to be more lenient and permissive, rather than trying to change their child’s behaviour (Glatz et al., 2012). The literature explores the notion of a liminal and transitory stage of drinking in adolescence, wherein alcohol consumption is deemed more acceptable and assumed to be short-lived (Berends et al., 2016). There is evidence that college students believe drinking is a rite of passage (Lewis and Hession, 2012), however, limited exploration of this belief is found in parents. If parents are adapting their beliefs to accommodate the social norm of underage drinking, and furthermore are engaging in strategies to reduce their concern about this behaviour, this may result in parents exhibiting more permissive parenting behaviours around alcohol consumption. This could, in turn, result in a further increase in underage drinking and exacerbate a vicious cycle of permissive social norms and increased drinking.

Although drinking in school age children is reported to be in decline (Fuller and Hawkins, 2013), the amounts reported in this study are still substantially less than current research would suggest (Bellis et al., 2009). Parents may under-report how much their child drinks for a number of
reasons, including a lack of awareness or social desirability effects (LaBrie et al., 2014). Contrary to expectation, this study also found that parents of younger children did not report that their child drank less than older children. This contradicts the finding that weekly drinking increases with school age (Currie et al., 2008). Equally, the finding that older parents reported their child drank greater amounts and more often is interesting, and appears to contradict research to suggest that older parents hold more conservative beliefs (Jones and Francis, 2015). There was no correlation between parental age and beliefs about underage drinking and no differences between older and younger parents, in terms of when they last talked to their child about alcohol. As such neither beliefs nor talking about alcohol provide possible explanations for our finding. Alternative reasons include more life experience, their own past experiences of drinking alcohol when they were young, confidence to report honestly or less awareness or exposure to the harms of alcohol, for example, via social media more commonly used by younger parents. Recent research suggests that middle age and older adults tend to drink more frequently than younger people (Alcohol Concern, 2015). Therefore, these parents may also hold beliefs about their child’s drinking that correspond to their own current drinking behaviour.

**Implications and recommendations**

Children may be receiving mixed messages in the home if the dually held beliefs identified in this study are commonplace (Eadie et al., 2010). On the one hand, they receive messages from parents, school and the media that alcohol can be damaging to health and wellbeing. On the other hand, parents may present a message that underage drinking is to be expected. Addressing parental beliefs about normalised drinking practice in young people may be an important consideration for public health campaigns (Smit et al., 2008). Research suggests parents may not recognise that public health campaigns and messages are aimed at them; therefore, it is essential the target audience is helped to perceive themselves as such (Jones et al., 2016). Historically, public health has focussed heavily on information giving. The results of this exploratory study suggest that parents have a relatively good understanding of the harmful effects of drinking on young people. What may be needed are interventions to challenge the normalisation of underage drinking.

“Frames” refer to the way information is presented, triggering our existing concepts and beliefs on a subject, which may be biased, helpful or inaccurate. “Re-framing” refers to methods designed to present information in a new way, in order to adapt these pre-existing ideas, enabling new assumptions to be formed. An example of re-framing in the field of obesity found that existing frames focussed on will power and the individual, further stigmatising obesity. By re-framing the focus onto the environmental, societal and political rather than individual behavioural context (e.g. adapting the environment to make health-enhancing choices easier to make), the authors propose public health can better support positive changes to health (e.g. Dorfman and Wallack, 2007). A “framing–re-framing” approach could be applied to public health messages, acknowledging that beliefs that underage drinking is a normal part of growing up are commonplace and understandable; however, demonstrating this belief in terms of permissiveness and parent–child communication can have a significant negative impact on adolescent drinking behaviour long term.

**Limitations of this study**

There are a number of limitations with the study. The sample is relatively small as a result of a low response rate, predominantly white British and mainly consists of the views of mothers. It is unclear if the views were the collective view of both parents’ combined or just mothers, and it was not possible to access demographic information about the non-responders who may have differed from respondents. It would have been helpful to ascertain whether parents had any children over 18 years of age, for whom they had already experienced the impact of underage and adolescent drinking, which may have influenced their beliefs in relation to later siblings. We cannot infer from these findings that these beliefs directly affect young people’s drinking behaviour, as this was not measured, and parental reporting may be subject to error and social desirability effects. However, research suggests that parental reporting is likely to be under rather than over-inflated (Engels et al., 2007; Guilamo-Ramos et al., 2006); therefore, actual drinking in young people is likely to be greater than reported here. Measuring parental drinking behaviour would also have enabled a better understanding of how their beliefs are formed.
The questionnaire was designed *de novo* and therefore lacked psychometric rigour. The items measuring drinking frequency would have benefitted from separating out “occasional” with “monthly” drinking, as patterns may have differed significantly, affecting the findings. The definition of “binge drinking” used in this study was “6 or more drinks on one occasion or heavy drinking for days or weeks followed by no drinking”. Although used by the local Public Health Department, it is not in line with the current national consensus of consuming five drinks in adolescents (Degenhardt et al., 2013). The latter part of the definition also includes what constitutes “problem” rather than binge drinking, and should have been a separate item.

This study would have benefited from a qualitative exploratory approach to better explore novel parental beliefs about underage drinking; whether parents feel their attitudes and beliefs impact on their child’s drinking behaviour, and in what ways; and the basis for which they estimate their child’s drinking behaviour. The addition of qualitative research to explore the dual belief concept, the role of cognitive dissonance and how parents interpreted the item “Drinking is a natural part of growing up” would also have enhanced the findings and conclusions drawn.

**Conclusions**

To the authors’ knowledge, this is the first study to report the widespread and potentially detrimental parental belief that underage drinking is a natural part of growing up, alongside the common dual belief that underage drinking poses risks of harm. Future research is necessary to explore in greater depth how and why these beliefs are formed and the impact long term on parental permissiveness and adolescent drinking behaviour.

**References**


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Do risk factors increase measurement of hepatitis B, C signs and HIV-AIDS among middle-aged and older IDUs in southwest Iran?

Abdolrahim Asadollahi and Abdolkarim Najafi

Abstract

Purpose – Injecting drug use addiction is a main factor in hepatitis B, C infection and HIV–AIDS infection. The purpose of this paper is to measure seroprevalence of hepatitis B, C virus and HIV–AIDS amongst injecting drug users (IDUs) and its influencing factors.

Design/methodology/approach – The cross-sectional method was used in mid-2017 in Ahwaz city, southwest Iran. In total, 133 IDUs, aged 29–71 years (mean age = 48.21 ± 10.4), were chosen from Aria addiction treatment centre. The data were collected on demographic and behavioural characteristics. In addition, serum samples were screened for those diseases.

Findings – In a total of 131 IDUs, 2 (1.5 per cent) were HIV+, 16 (11.7 per cent) HCV+ and 8 (6.1 per cent) HBV+. There was a significant correlation between diseases and IDU. Results of multiple regression stated that IDU was a more predicting variable as β = 0.76 and the model was able to predict 74.1 per cent of the variance, F (3, 35) = 12.42, p < 0.001, R2 = 0.741, OR = 3.01, 95% CI [1.44, 3.83]. The synchronised pairwise effect of age, imprisonment and IDU with GLM analysis was significant, F (2, 114) = 20.433, p < 0.001, Z2HCV+ = 0:609, Z2HBV+ = 0.616, and Z2HCV = 0.612, λMML = 0.056. The infection rate among IDUs was significant and the most important risk factor for these infections has been intravenous drug use, together with age of misusing and imprisonment.

Research limitations/implications – The non-cooperation of two samples, lack of participation of three addiction rehabilitation centres in Ahwaz city, the end of cooperation in the first two months of the implementation of the plan, and the lack of consistency of the three serum samples in the cases (two cases) were limitations of the study.

Practical implications – Based on the results, the following suggestions could be presented: establishing “Intervention Clubs” for treatment in the peripheral urban areas for the participation of women drug users – the responsible organisation is Cultural and Social Deputy of Ahwaz Municipality Organisation; integration of “Small Self-caring Groups” in Sepidar Women’s Penitentiary in the East Ahwaz region – the responsible organisation is Khuzistan Province Prisons Organisation (the southwestern Iranian prisons authority); constructing “Community-based Committees” to increase the level of social intervention – the responsible organisation is the Iran Drug Control Headquarters at Iranian Presidential Office; screening of injecting drug use in the populations at risk, especially girls and women in marginalised areas – the responsible organisation is Deputy Director of Prevention and Treatment of Addiction in the Iran Welfare and Rehabilitation Organisation; establishing an “Patient Treatment Center” in high-risk areas along with directing drug users and supervising the relevant authorities – the responsible organisation is Deputy Police Commander on Social Assistance; providing education to families involved with addiction in the “Neighborhood Parks” – the responsible organisation is Deputy for Health Affairs.

Social implications – They are mixed with practical implications as well.

Originality/value – The comprehensive harm reduction plan and prison-related issues of IDUs with shared syringe along with the pairwise age and imprisonment need to consider the above factors.

Keywords Iran, Risk factors, HIV–AIDS, IDU, Mid-life and elderly, Viral hepatitis

Paper type Research paper
1. Introduction

Injecting drug users (IDUs) are a group of people who are exposed to a variety of infections due to high-risk behaviours, especially the use of common injectable drugs (Burattini et al., 2000). Jarlais and his co-workers have defined IDU as the following: “drug injection is a method of introducing a drug into the bloodstream via a hollow hypodermic needle and a syringe, which is pierced through the skin into the body. As of 2004, there were 13.2 million people worldwide who used injection drugs, of which 22 per cent are from developed countries” (Jarlais et al., 2016). Hepatitis C, B virus (HCV and HBV), and human immunodeficiency virus (HIV-AIDS) are the most significant infections. In terms of cell structure, these viruses have lipid covering and in terms of the way of transmission, these are blood borne (Focà et al., 2016). The shared use of syringes is one of the most important risk factors for transmission of these infections among IDUs (Buavirat et al., 2003; Samuel et al., 2001; Stark et al., 1997; Broz et al., 2014). The prevalence of blood-borne hepatitis is usually higher among IDUs than non-IDU populations (Brouard et al., 2013; Lea et al., 2013). Epidemiological data show that IDUs are the most significant group of people with hepatitis C (Ghahremani et al., 2018; Saha et al., 2000). Today, hepatitis B and C are among the most important health priorities in the world and prevention of these two major diseases is considered important. The reason for this is that 5–10 per cent of cases of hepatitis B and more than 50 per cent of cases of hepatitis C will lead to chronic liver disease. There is also the possibility of transmission of these two diseases through sexual contact with sexual partners, as well as from mother to foetus and baby, which is more likely to be associated with hepatitis B (Brouard et al., 2013; Saha et al., 2000). It has now been highlighted that preventing hepatitis C in high-risk populations, including HIV-positive men and women, is very important because of the onset of hepatitis C in these patients will lead to faster progression to chronic hepatitis, cirrhosis, and hepatic malignancy around the globe (Brouard et al., 2013; Saha et al., 2000). There is evidence of an increasing trend in blood-transmitted diseases among IDUs in different regions (Saha et al., 2000; Zhang et al., 2002). HIV infection is one of the most important health problems of the international community and one of the important factors is shared needle and syringe use by IDUs. Major epidemics in IDUs have been reported in about half of North Africa and the Middle East, including Iran. About 65 per cent of cases of known HIV-positive patients in Iran are related to injecting drug use (The Ministry of Health and Medical Education of Iran, 2002; Baratvand et al., 2013). Determining the risk factors for HCV, HBV, and HIV–AIDS in IDUs is important in order to provide effective prevention to reduce the spread of these diseases. Due to the lack of regional studies, papers, and factsheets, especially amongst the population of female drug users in our country, regarding the prevalence of infections due to blood transfusion, especially hepatitis B, C virus, and HIV–AIDS in IDUs, the study aimed to determine the prevalence of serum, its association with important behavioural factors, and the risk of developing these three diseases in this population in Ahwaz city, southwest Iran, in mid-2017.

2. Materials and methods

In a cross-sectional study between the 3 June and 26 August, 2017, from 437 patients engaged with Aria Comprehensive Addiction Centre in Ahwaz city, 133 addicts with a history of shared syringe use and addiction to injectable drugs were chosen with the convenience sampling method. Their blood serum was evaluated for anti-hepatitis C, HIV–AIDS, and antigen levels of hepatitis B by the ELISA method. All positive cases from the ELISA analysis of HIV–AIDS and HCV by immunoblot method were also evaluated (WB, Gene Labs Diagnostics, Ltd). For patients with positive results, years of imprisonment (incarceration) were determined in the general linear model (the multiple GLM) analysis. This refers to a conventional linear regression model for a continuous response variable given continuous and/or categorical predictors, and it is a flexible generalisation of ordinary linear regression that allows analysis of multiple interpretation for more than two variables in both independent and dependent variables (DVs). Data from two subjects were discarded because they did not agree to participate in the study.

A researcher-designed questionnaire was applied, containing age, sex, years of imprisonment and shared syringe use. Other criteria for the study included referring to the recent year and having a clinical case at the centre; being at least 20 years of age; expressing consent to participation in the study and the taking of serum samples; being a resident in Ahwaz city; availability of patients who abandoned the process of treatment for addiction; being continuously at the clinic, having a file that
was complete in terms of demographic and clinical components. Imprisonment and/or incarceration was defined as the state of being confined in prison. Initially, all subjects received a form to show informed consent before providing serum samples, describing the process and objectives of the study, and in this process, a clinic specialist had direct supervision. The assumptions of GLM (VIF, homogeneity of variances for each group and normal distribution of independent variables [IVs] and DVs, i.e. skewness, kurtosis, D’Agostino and Pearson normality test (3.172, Kolmogorov–Smirnov (0.264), Shapiro–Wilk (0.279)) and the reliability of using it was estimated and approved (Rencher, 2003). Thus, it can be concluded that sampling and allocation of the subjects to the groups was correct from a statistical viewpoint (ρ value < 0.02). The data were analysed by Pearson correlation, χ² test, multivariate regression, and GLM in SPSS-IBM-25. A diagram of causal model was applied by DAGitty®, a browser-based environment for creating, editing, and analysing causal models.

3. Findings

Of 131 participating patients, 129 (98.47 per cent) were male and 2 (1.52 per cent) were female. The mean age of this population was 48.21 ± 10.4 years (29–71-year old). 16 samples (11.2 per cent) were HCV+, 8 (6.6 per cent) HBV+, and 2 (75 per cent) were HIV–AIDS+. All of these were male. The mean age of patients with hepatitis C and B was 49.4 ± 4.7 and 41.1 ± 4.8 years, respectively. According to the χ² test, there was a significant correlation between shared syringe use and the risk of HCV, HBV, and HIV–AIDS+ (p < 0.01) (Table I). Two samples (a 37-year-old, single, unemployed man, and a 51-year-old middle-aged married man) who had a history of sharing needles and syringes and of imprisonment were HIV-positive.

The logistic regression analysis was used to develop a model for predicting point average of HBV, HCV and HIV–AIDS (Table II). Basic descriptive statistics and regression coefficients are shown in Table II. Each of the predictor variables had significant (ρ < 0.01) as well as the IDUs predictor (ρ < 0.05) partial effects in the full model. The three-predictor model was able to account for 74 per cent of the variance in HBV, HCV, and HIV–AIDS points (DV), F (6, 75) = 12.14, ρ < 0.001, R² = 0.74, 95% CI [1.0, 4.8].

The GLM box’s test of equality of covariance matrices of positive hepatitis types B and C, and positive HIV–AIDS virus has estimated the GLM assumptions and it has statistically indicated the equity of covariance of DVs in F (14, 121.06) = 3.381, ρ = 0.258 and Box’s M = 3.381. The significant difference was estimated between the groups in terms of HBV+, HCV+, and HIV–AIDS + as DVs. It can be realised as F (14, 121.06) = 3.381, ρ < 0.000. It can be said that IVs statistically have a significantly effective role for the DVs. Regarding the well-known test of Wilks’ λ, the IDU (λ = 0.641, ρ < 0.000), imprisonment (λ = 0.423, ρ < 0.000), age (λ = 0.233, ρ < 0.000) and IDU × imprisonment × age (λ = 0.704, ρ < 0.000) statistically illustrate the significant and effective means difference within groups among three normal distributed IVs (age, IDU and imprisonment) on DVs.

The Levene’s test of equality of error variances of DVs within the IVs was used in GLM method and measures of ρ mention statistically significant differences of error variances.

Table I. Behavioural patterns with HIV–AIDS, HBsAg and HCVAb infection of Ahwazi IDUs

<table>
<thead>
<tr>
<th>Factors</th>
<th>HIV–AIDS</th>
<th></th>
<th>Type of blood infection</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>Type of blood infection</th>
<th></th>
<th></th>
<th>Mean age</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sharing needle using and syringe</td>
<td>2</td>
<td>1.52</td>
<td>107</td>
<td>81.67</td>
<td>7</td>
<td>3.05</td>
<td>105</td>
<td>88.15</td>
<td>13</td>
<td>9.92</td>
<td>107</td>
<td>82.30</td>
</tr>
<tr>
<td>No sharing needle using and syringe</td>
<td>0</td>
<td>0</td>
<td>22</td>
<td>16.79</td>
<td>1</td>
<td>0.76</td>
<td>18</td>
<td>13.74</td>
<td>3</td>
<td>2.29</td>
<td>8</td>
<td>6.11</td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
<td>1.52</td>
<td>129</td>
<td>98.46</td>
<td>8</td>
<td>3.81</td>
<td>123</td>
<td>101.89</td>
<td>16</td>
<td>187</td>
<td>88.41</td>
<td>39.4</td>
</tr>
<tr>
<td>Imprisonment</td>
<td>1</td>
<td>0.76</td>
<td>117</td>
<td>89.31</td>
<td>6</td>
<td>2.29</td>
<td>116</td>
<td>88.54</td>
<td>12</td>
<td>9.16</td>
<td>111</td>
<td>84.73</td>
</tr>
<tr>
<td>No record of imprisonment</td>
<td>1</td>
<td>0.76</td>
<td>12</td>
<td>9.16</td>
<td>2</td>
<td>1.52</td>
<td>7</td>
<td>5.34</td>
<td>4</td>
<td>3.05</td>
<td>4</td>
<td>3.05</td>
</tr>
<tr>
<td>Total</td>
<td>1</td>
<td>1.52</td>
<td>129</td>
<td>98.47</td>
<td>8</td>
<td>3.81</td>
<td>123</td>
<td>93.88</td>
<td>16</td>
<td>12.21</td>
<td>115</td>
<td>87.78</td>
</tr>
</tbody>
</table>

Notes: n = 131. HBsAg, Hepatitis B surface antigen; HCVAb, Hepatitis C virus antibody; HIV, human immunodeficiency virus.
In the DV of HIV+, value of F (102, 125) was 2.396 ($p > 0.233$), in the HBV+, F (102, 120) was 2.106 ($p > 0.163$), and in the HCV+, F (102, 121) was 2.101 ($p > 0.319$). It means that the error variances of IVs in the DVS statistically have a significant difference to each other and are unequal. The acceptance of null hypothesis in the Levene’s test validates the following measures in the GLM report (Stevens, 2012).

The between-subjects effects of model of GLM in total and separately on HIV+, HBV+ and HCV+ are used. Independent effect of IDU on DVS statistically assume significant difference of mean values of the HIV–AIDS + ($F = 1.010, p < 0.000$), HBV+ ($F = 2.121, p < 0.000$), and HCV+ ($F = 2.131, p < 0.000$) between IDUs. Additionally, the independent effect of imprisonment on DVS statistically assume significant difference of mean values of the HIV+ ($F = 5.111, p < 0.000$), HBV+ ($F = 5.702, p < 0.007$) and HCV+ ($F = 5.248, p < 0.002$) between groups, as well as independent effect of imprisonment on DVS statistically assume significant difference of mean values of the HIV+ ($F = 3.064, p < 0.008$), HBV+ ($F = 2.405, p < 0.001$), and HCV+ ($F = 2.327, p < 0.003$) between age groups. In addition, the mixed effect of age, imprisonment (incarceration), and IDU was assumed as well. The significant effect of pairwise comparison of IDU x Age x Imprisonment on DVS statistically indicates the difference of mean values of the HIV+ ($F = 2.969, p < 0.000$), HBV+ ($F = 1.626, p < 0.000$) and HCV+ ($F = 1.287, p < 0.000$) between groups.

The $R^2$ and $R^2_{adj}$ show that 46.7 per cent of variances of imprisonment ($F = 6.420, p < 0.000$), 58.1 per cent variances of HBV+ ($F = 3.818, p < 0.000$) and 56.7 per cent variances of HCV+ ($F = 3.818, p < 0.000$) have been estimated by the total model. The values of the last column, partial $\eta^2$, were used for all IVs on DVS and yield significantly effective relationships between IVs and DVS. The partial Eta-squared is a measure of effect size for use in ANOVA and it ranges between 0 and 1, where 1 means the highest affection of IVs on DVS. The partial $\eta^2$ measures magnitude of the effective relationships between more than independent and DVS (Rutherford, 2001). The effective relationship of IVs independently on DVS is as below:

- **IDU**: $F (4, 130) = 2.140, p < 0.000$, $\eta^2_{adj} = 0.0416$, $\eta^2_{HBV+} = 0.412$ and $\eta^2_{HCV+} = 0.419$, $\lambda_{adj} = 0.023$. It can be claimed that IDU statistically has a significant effect on DVS and it has independently clarified 41.6 per cent of HIV+ variances, 41.2 per cent of HBV+ variances and 41.9 per cent of HCV+ variances.

Along the same lines, the independent significant effect of age and imprisonment is as below:

- **Age**: $F (8, 118) = 2.375, p < 0.006$, $\eta^2_{HBV+} = 0.234$, $\eta^2_{HBV+} = 0.218$ and $\eta^2_{HCV+} = 0.219$, $\lambda_{adj} = 0.037$. It can be claimed that age statistically has a significant effect on DVS and it has independently clarified 41.6 per cent of HIV+ variances, 41.2 per cent of HBV+ variances and 41.9 per cent of HCV+ variances.

- **Imprisonment**: $F (8, 120) = 2.030, p < 0.006$, $\eta^2_{HBV+} = 0.347$, $\eta^2_{HBV+} = 0.333$ and $\eta^2_{HCV+} = 0.333$, $\lambda_{adj} = 0.056$. It can be claimed that imprisonment statistically has a significant effect on DVS and it has independently clarified 33.7 per cent of HIV+ variances, 33.3 per cent of HBV+ variances and 33.3 per cent of HCV+ variances.
Accordingly, a synchronized pairwise effect of age, imprisonment and IDU was assumed as well, and their effective relationship cooperatively on DVs is as below:

- The pairwise comparison of IDU×Age×Imprisonment: F (2, 114) = 20.433, ρ < 0.000, η²_HIV+ = 0.609, η²_HBV+ = 0.616 and η²_HCV+ = 0.612, λ_Wilks' = 0.056. It can be claimed that pairwise comparison statistically has a significant effect on DVs and it has independently clarified 60.9 per cent of HIV+ variances, 61.6 per cent of HBV+ variances and 61.2 per cent of HCV+ variances.

According to Figure 1, area under the curve in prediction of HCV, concerning years of IDU and imprisonment, was illustrated and it could be said that years of IDU with area under the curve (AUC) = 73.1 per cent (ρ = 0.006) is more significantly predictable for HCV than years of imprisonment (AUC = 46.5 per cent). The bootstrap sampling method recognises this significant difference as well (ρ = 0.006).

The ROC is also designed to predict HBV and HIV but AUC in the years of IDU and then imprisonment was 72.8 and 50.1 per cent, respectively, which did not approve significant difference in prediction (ρ = 0.143), and in predicting HIV, the AUC was 52.5 and 59.5 per cent, respectively, with an insignificant difference (ρ = 0.854).

3.1 Causal model in risk factors of IDUs

A diagram of causal model regarding IDUs’ risk behaviours was applied and generated by DAGitty®, a browser-based environment for creating, editing and analysing causal models (Textor et al., 2011). According to Figure 2, the predicting coefficient of the pairwise comparison of IDU×Age×Imprisonment has higher score on the risk behaviours of the samples. The lowest predictive variable is age, which is located at the lower left corner of the causal diagram.

4. Discussion

Injecting drug use is a key factor in the transmission of blood pathogens. Epidemiological studies show that the risk factors associated with drug injection, the duration of IDU, the type of injectable drug, and shared needle and syringe use are directly and indirectly associated with the spread of hepatitis B, C virus and HIV infection (Tortu et al., 2003). In a study in Copenhagen, of 291 drug users tested, 3.4 per cent samples were HIV positive, 64 per cent were HBV positive and 75 per cent were HCV positive (Fuglsang et al., 2000). In a study in Nepal, of 72 IDUs, 80 per cent
were positive for HCV and HBcAb, but only 5.5 per cent were positive for HBsAg (Shrestha et al., 1996). In a cross-sectional study, the markers of different HBVs were studied in the illegal settlements of Ahwaz city: 35 out of 254 were HBsAg positive and 54 were HBcAb positive (Hoseiniasl et al., 2004). The lower rates of hepatitis B in this study can be due to the fact that HBsAg was the only marker that could be studied in the study, whereas in other studies, other HBV markers were also investigated (Zali et al., 2005).

In both Alavian et al. (2002) and Zali et al. (2005) studies, the prevalence of HCV among Iranian subjects was 11.2 per cent, whereas in other studies, it was reported as more than 80 per cent (Alavian et al., 2002; Zali et al., 2005). They also showed a much lower rate of HIV infection compared with other studies, whereas 65 per cent of known HIV cases were drug users in Iran (Alavian et al., 2002; Zali et al., 2005) The reason for these differences can be explained as about 5–7 per cent of the population has an addiction to drugs, with more than 50 per cent of them sharing needles and syringes (Razzaghi et al., 2006). The shared needle and syringe use in our population was less than expected. Another reason for these differences is the relatively long-term change in the pattern of drug use from smoking to injecting at our community level, which means that the history of injecting drug use is relatively shorter than in other societies (Hoseiniasl et al., 2004). People referred to voluntary drug addiction centres were informed about their own status, especially HIV. The HIV-positive cases did not come about due to social incidents. In this study, the selected group has been among addicts who have been admitted to drug treatment centres and it does not include all IDUs. In this study, shared injection has been proven as an important factor in the development of infections ($p < 0.05$), which is also shown by other studies (Alavian et al., 2002; Zali et al., 2005).

In spite of the lower prevalence of illnesses compared to other studies, these diseases show a higher incidence than in the general population in Iran, which is 1.5, 2.1 and 0.2 per cent for viral hepatitis B and C and HIV positive, respectively (Alavian et al., 2002; Zali et al., 2005). In general, the results of the GLM model have shown that the combination of age, prison history and injection with shared needle and syringe use can increase the risk of hepatitis B, C virus and HIV-positive incidence. Given the increasing rate of IDU in Iran (Razzaghi et al., 2006) the need for harm reduction programs is absolutely necessary.

Two important strategies to achieve this goal are recommended. First, community-wide education focussed on populations at risk, especially amongst the population of female drug users in our country. This is a special group that is usually neglected due to social taboos and the cultural customs in the Middle East and North Africa. Interestingly, the two women in our study belonged to the Arab ethnic group wherein accessibility to their data and interviewing posed a sensitive situation for the authors who are from the Persian ethnic group. Second, practical interactions,

![Figure 2](image-url)
such as counselling, distribution of free syringes, and the use of cultural, racial, and community tools, aimed to prevent the spread of these diseases. It is also necessary to conduct more extensive studies in this high-risk population, especially incarcerated men and female drug users. In this study, it was found that IDUs have a higher incidence of infection than normal population (Alavian et al., 2002; Razzaghi et al., 2006). On the contrary, the main risk factor for these infections is injecting drug use and shared needle and syringe use, along with imprisonment and years of age.

5. Conclusion
The synchronised pairwise effect of age, imprisonment, and IDU is important to the improvement in the situation of IDUs as part of a comprehensive health plan to reduce drug use and promote harm reduction within older and mid-life addicts. The non-cooperation of two samples, lack of participation of three addiction rehabilitation centres in Ahwaz city, the end of cooperation in the first two months of the implementation of the plan and the lack of consistency of the three serum samples in the two cases were limitations of the study. Based on the results, the following suggestions could be made:

1. Establishing “Intervention Clubs” for treatment in the peripheral urban areas for the participation of women drug users: the responsible organisation is the Cultural and Social Deputy of Ahwaz Municipality Organisation.

2. Integration of “Small Self-Caring Groups” in Sepidar Women’s Penitentiary in the East Ahwaz region: the responsible organisation is Khuzistan Province Prisons Organisation (the southwestern Iranian prisons authority).

3. Constructing “Community-based Committees” to increase the level of social intervention: the responsible organisation is the Iran Drug Control Headquarters at the Iranian Presidential Office.

4. Screening for injecting drug use in the populations at risk, especially girls and women in marginalised areas: the responsible organisation is the Deputy Director of Prevention and Treatment of Addiction in the Iran Welfare and Rehabilitation Organisation.

5. Establishing a “Patient Treatment Centre” in high-risk areas along with directing drug users and supervising the relevant authorities: the responsible organisation is the Deputy Police Commander on Social Assistance.

6. Providing education to families involved with addiction in the “Neighbourhood Parks”: the responsible organisation is the Deputy Director for Health Affairs.

Except for the fourth suggestion, which needs to be strengthened, the suggestions are not currently implemented at either local or national level. They seem to be based on the studies that are effective elsewhere in controlling the spread and consumption of drug use in the community, especially amongst marginalised female drug users (Merghati-Khoei et al., 2018; Shahbazi et al., 2017).

Acknowledgements
The authors declare that they have no competing interests. The ideas expressed are those of the authors and do not necessarily reflect Aria Comprehensive Rehabilitation and Addiction Centre, Ahwaz, Iran. Not commissioned; externally peer reviewed. Written and verbal consent of patients was obtained before participation in the study. Ethical matters, e.g. plagiarism, informed consent, misconduct, data fabrication and/or falsification, double publication and/or submission, redundancy, etc., have been fully observed by the authors. All the participants received a verbal explanation about the study objectives and procedures, and then they signed written informed consents for taking part in the study. The participants were also reassured about the anonymity and confidentiality of their information. Also, the ethics committee of the Ahwaz Jundishapur University of Medical Sciences has approved the research with ethical No: IRAJUMS.PHNM1396-6421. All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments including informed consent and confidentiality of all personal information. AN has contributed to the design, performed the interviews, and supervised the extraction of blood samples. AA has interpreted
the methods and results and written the draft and discussion; both authors have approved the final manuscript as well. The authors wish to express their gratitude to the editor, all colleagues and the anonymous reviewers for their helpful comments.

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