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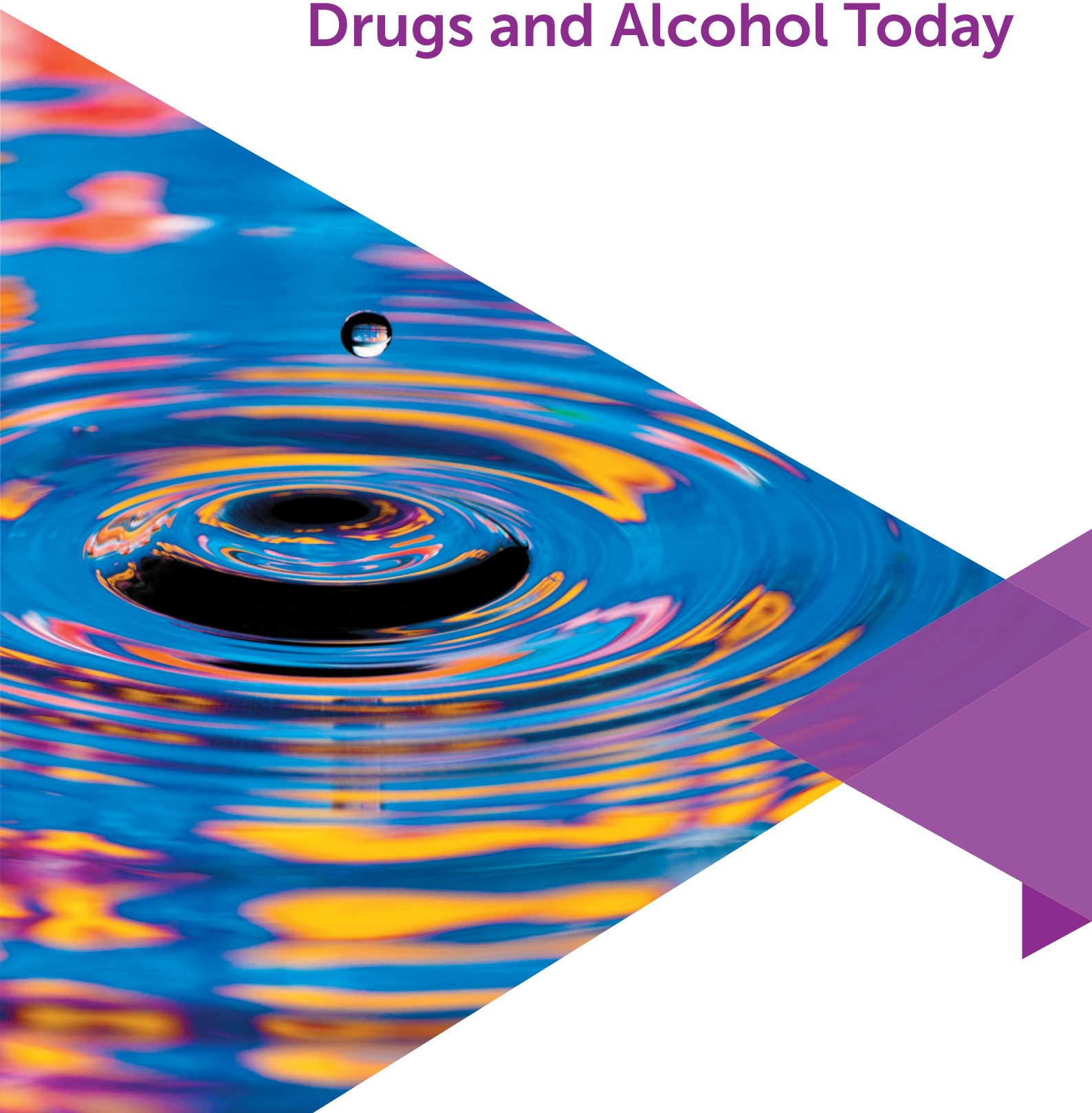

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Editorial

Blaine Stothard and Axel Klein

In this issue

Our first regular issue of 2019 includes a spread of topics which illustrate the many aspects of the drug and alcohol field – mortality, consumers (of drugs and alcohol, and of treatment services) and identities.

In their order of printing, we begin with an account by Bergamo, Parisi and Jarre of a drug consumption room/safer injection facility in Italy, established and run by drug users. In common with other DCRs in Europe, its operations have contributed to improved health amongst the drug-using population it serves and there have been no overdose deaths. McPhee, Sheridan and O'Rawe writing on drug-related deaths in Scotland question the focus on an ageing drug-using population as lying behind the increased death rate. The paper assesses the impact of the UK's Misuse of Drugs Act and how its misconceived focus on abstinence at a time of increasing poverty and deprivation contributed to an increase in drug-related deaths.

Leigh and MacLean point to another striking inadequacy of the 2017 UK Drug Strategy: no mention of volatile substance abuse (VSA). Using an ONS report, the paper shows how VSA is not combined with other substances, most notably alcohol. The authors raise the question of the linkage between VSA and social deprivation with a sharp rise in of VSA incidence amongst the 11–15 age group. The role of social deprivation is also explored by McPhee *et al*.

Two papers look at patient (or user or consumer) involvement in and with drug and alcohol treatment services. From Australia, Goodhew Stein-Farbury and Dawson conducted a literature review on "consumer" participation in treatment and its contribution to treatment outcomes. Morton and O'Reilly present a case study which examines practitioners' understandings of challenges, user involvement, relationship building and outcomes in a community-based low-threshold treatment service in Dublin. It includes the notion of safe space. The Australian piece uses the terminology of "consumer" in its text, a further indication that politicians and decision makers are not always willing or able to recognise and respond to drug and alcohol use as being a well-established market, with all the implications that have for consumer rights, information sharing, product quality and safety, and the role of regulation, acknowledge or denied. In the UK context, it is significant that "official" terminology persist in referring to "service user involvement or voice", this seemingly denying the potential value and role of user voice. This in itself might be part explanation of the increasing irrelevance of UK Government strategies to the realities and extent of the use of currently illegal drugs – "nothing about us without us" as the activists say. The two papers also raise the question of whether shared involvement in service provision, users and providers also implies shared responsibility for treatment outcomes.

Savonon's paper on media representations of polysubstance use in Finland tracks the changes in approach and language regarding polysubstance use in one Finnish newspaper between 1990 and 2016. This historical approach also shows the change in polysubstance use in Finland, from principally alcohol and medications to a wider range of substances as they emerged. McPhee, Holligan, McLean and Deuchar present their findings from research amongst a small sample of competent clandestine users of drugs to show the heterogeneity of drug use and users, and the extent of knowledge of the contexts and implications of their use existing amongst most users. The fact that this knowledge and use is mostly hidden is ascribed to generally negative attitudes and stigmatism amongst the wider population, leading to identity concealment. A similar message emerges from Kiepek's paper which looks at the use of illegal drugs amongst a group of Canadian social workers.

While this collection of papers encompasses a range of geographically and demographically specific situations, it is clear that there are also wider, more universal lessons and conclusions to be drawn from each of them. The editors' own work, experience and reading have found us in several situations where decision makers have been reluctant to accept such conclusions because the study or research in question did not take place in X or involve study of group Y, a response which might be seen as contributing to a refusal or inability to acknowledge that all is not well with drug and alcohol policy in many jurisdictions. A recurrent example of this was most recently expressed in an October 2018 House of Commons debate on drug consumption rooms when the minister replying to the debate misrepresented the INCB position on DCRs in order to justify governmental inertia on this issue.

The editors are gratified to see the number of nations represented by the papers, both by the geographical settings and the authors. The collection of topics and studies and the careful exposition of settings and implications are valuable and significant, and an encouragement to the editors to continue to encourage and promote such variety.

Harm reduction in Italy: the experience of an unsanctioned supervised injection facility run by drug users

Sonia Bergamo, Giuseppe Parisi and Paolo Jarre

Abstract

Purpose – *Efforts to establish harm reduction interventions in Italy have persisted since the mid-1990s. Despite this, no sanctioned SIF has ever been implemented. The purpose of this paper is to provide information about a 10 year unsanctioned drug user-run SIF experience in Italy called Stanzetta.*

Design/methodology/approach – *The aim of the paper is to assess how Stanzetta met its objectives. Analysis was conducted compiling narrative accounts from the staff working in the NSP, which is adjacent to the Stanzetta, and conducting a simple frequency analysis of the available statistical data.*

Findings – *The Stanzetta unsanctioned SIF has been running for ten years and continues to be vulnerable due to its legal status. Being open 24 h/days has maximised its accessibility, but at the same time, it has encouraged a misuse of the Stanzetta. Although not trained, drug users became self-empowered to run the Stanzetta and to keep it clean, but the hygiene-health aspect is seen as one of the greatest challenges by the NSP professional staff. Over 10 years, not a single overdose death has been recorded. Drug use in the park has shifted from more visible places to the Stanzetta. As a result, the abandoned syringes have diminished in number and those disposed of correctly have increased. Moreover, no complaints from citizens or law enforcement were ever made. The neighbourhood acceptance seems to be the main goal of the peer-run unsanctioned SIF.*

Research limitations/implications – *The paper is based on a narrative account from the point of view of the professional staff involved, and results are specific to the context in which the study was conducted. Because of the chosen approach, the research results lack scientific generalisability. A relevant limitation is that no peer was involved in this study. Despite this, the research contributes to the information based on peer-run SIFs and makes a case for the de-medicalisation of SIFs in Europe.*

Practical implications – *This paper gives visibility to a long-lasting drug user-run SIF experience that was not made public mostly for an unclear legislative background about SIF in Italy.*

Social implications – *Efforts to establish harm reduction interventions in Italy have persisted since the mid-1990s and were undertaken primarily in response to epidemics of HIV infection and overdose (DPA, 2017). Despite this, no sanctioned SIF has ever been implemented. Primarily, this study wants to underline the urgency for an SIF pilot in Italy, and secondly the need to consider de-medicalising these services through direct support for peer-based models.*

Originality/value – *The Stanzetta unsanctioned SIF in Italy that has been running for ten years. Despite this, the venue continues to be vulnerable due to its legal status. For this reason, these results were never made public before. The experience showed a good working synergy between NSP professionals and the SIF peers. This model can be considered as a "light" de-medicalisation form to be explored and eventually to be implemented as a pilot SIF in Italy.*

Keywords *Harm reduction, Drug consumption rooms, Italian drug policies, Peer-run SIF, Safe injection rooms, Unsanctioned SIF*

Paper type *Case study*

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1. Introduction

Safe injection rooms (SIFs) are venues that "provide hygienic environments in which people who inject drugs (PWID) can use illegal drugs under the supervision of a health care professional, a trained allied service provider, or a peer (i.e. person who formerly used or currently uses illegal

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drugs), without the risk of arrest for drug possession" (BCCSU, 2017, p. 6). They constitute "a highly specialised drugs service within a wider network of services for drug users, embedded in comprehensive local strategies to reach and fulfil a diverse range of individual and community needs that arise from drug use" (European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), 2004, p. 8). This conclusion also appears in more recent EMCDDA publications on SIFs European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2018), SIFs provide a broad range of social and health services in a safe environment for marginalised populations of drug users who experience a range of health and social harms (Atkin-brenninkmeyer *et al*., 2017, p. 1). There is a great variance in the services provided in SIFs and their characteristics, due to the different legal, social and local environments they are operating in (Belackova *et al*., 2017; Stone *et al*., 2015). Evaluations have addressed the impact of SIFs on drug-related deaths, health of drug users and public nuisance (e.g. DeBeck *et al*., 2011; EMCDDA, 2004; Hedrich and Hartnoll, 2015; Kimber *et al*., 2003; Lloyd and Hunt, 2007; Lloyd-Smith *et al*., 2009; Potier *et al*., 2014; Salmon *et al*., 2007; Small *et al*., 2008; Thein *et al*., 2005). In particular, community-based studies in Canada have allowed the impact of SIFs to be quantified with greater confidence (e.g. Kerr *et al*., 2006, 2007; Wood *et al*., 2004). Last available data show that there are 92 operating SIFs in Australia, Canada, Denmark, France, Germany, Luxembourg, Netherland, Norway, Spain and Switzerland (Belackova *et al*., 2017). Although numerous studies have been able to illustrate SIFs effectiveness, it has been neglected to examine in the same way unsanctioned SIFs that are run by peer drug users (Jozaghi, 2015). Although Italy has long-standing experience in harm reduction policies, it has never implemented a sanctioned SIF. However, at local level, some significant experiences that could support national changes have been implemented. One of these is the SIF in Collegno (a suburb of Turin) that is being run by drug users for more than 10 years without official sanction or permit. The paper provides a narrative account from the staff involved in the adjacent needle syringe programme (NSP) service that is composed of one MD four professional educators, one psychotherapist and one sociologist. The authors also conducted a simple frequency analysis of the available statistical data.

2. Backgrounds

2.1 Harm reduction in Italy

In the early 1990s, when HIV/AIDS spread among drug users, Italian public institutions began to consider harm reduction policies (DPA, 2017). In the subsequent years, interventions mainly concerned the oversight of open drug scenes by outreach workers who provided sterile injecting materials. Later, automatic dispensers/exchangers were introduced, and only a decade later, NSPs and outreach units were established. At present, they are concentrated in the northern part of the country. In 2015, the 189 NSPs estimated were concentrated in four regions: Lombardy, Latium, Piedmont and Emilia Romagna. The majority of NSPs are funded from a regional government budget (DPA, 2017). In 2016, drug-related deaths in Italy were 266, 76 per cent of them were caused by opioids (DPA, 2017). In 2017, harm reduction interventions officially entered the LEA -National Essential Assistance Levels (DPCM, 2016, No. 40). The LEAs establish the right for every citizen to access specific health services provided by Local Health Authorities. Consequently, the debate on SIFs in Italy is going to get a new impetus. Italy is one of few EU countries to not have started a pilot project for the implementation of an SIF. Some experiences, like the one described below, remained obscure mostly for legislative reasons. Implementing SIFs is often complicated by drug laws that forbid drug possession and, thus, could make drug consumption on-site at an authorised service legally ambiguous (EMCDDA, 2004). In Italy, in particular, a section of the Criminal Code (Governo Italiano, 1990)[1] has been used to argue that operation of an SIF is, potentially, illegal. For this reason, the proposal for an experimental SIF project made by the mayor of Turin in 2003 was rejected even though the emergency of 2002 in Turin fully represented the reasons for the creation of an SIF as described in some international experiences: a peak of opiate overdose deaths (38 in 2002), many of them in public places, which brought discussion of the problem into the municipal agenda (European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), 2015; Canadian Centre on Substance Use, 2017; Waal *et al*., 2014). The responsible committee, however, concluded with a very cautious technical-political opinion that made the

administration not to assume political and pragmatic responsibility for the innovation, underlining the importance of "problems relating to social representations and ethical issues" (Comune di Torino, 2003).

2.2 Stanzetta: the unsanctioned drug user-run SIF

Starting from 2003, some of the towns in the suburbs of Turin found new ways to deal with issues related to the consolidation of open drug scenes. During the 1990s and 2000s, a large-scale sale and consumption of heroin could be observed in Collegno[2] (COBS, 2003). The Collegno area belongs to the jurisdiction of the Azienda Sanitaria Locale Torino 3 (ASL TO3) that is a local health institution. The area of responsibility of ASL TO3 extends from the western periphery of the city of Turin, in Northern Italy, to the border with France along the Val di Susa and Sangone. It is an area with 584,000 inhabitants (data 2016). According to the most recent available data, drug addiction services in this area were looking after 1,800 clients (OED, 2015). Paolo Jarre, Director of the Department of Pathology of Addictions at ASL TO3, said: "In 2002 we drew up a project for a SIF to be submitted to the Piedmont Region for funding under Law 309/90. It was called *Coverdose* and, although it was undersigned by the General Director of ASL, it was rejected by the Regional Commission for formal reasons […] This project preceded and was in part reiterated in the Turin proposal[3]". The proposal was backed by an informal initiative carried out in the same area by the team of outreach workers and peer workers[4] of the *Sottovento* outreach unit. From March to August 2003, drug users could use a "shooting gallery" nicknamed as *Nascosala*, created through voluntary action by drug users (hence, it is not a proper SIF). It was set up spontaneously in an abandoned building situated in a park that had long been used for drugs consumption, with the consequent unsafe discarding of syringes, vials, papers, dirty tissues, etc. The intentional reuse of syringes took place, with serious health consequences. During their routine outreach work[5], social workers became aware of this building and, to remedy the poor hygienic conditions, cleaned and disinfected the rooms, provided chairs, a table, a water can[6], waste-paper baskets and containers for used syringes. Moreover, naloxone[7] (a life-saving drug in the case of heroin overdose) was left there should it be needed. In a short time, due to the natural "buzz on the streets", the number of users of *Nascosala* increased. On 13 August, the police sealed the doors to make the place inaccessible.

In 2007, ASL TO3 took once again the initiative to set up a formal SIF in the same park (*Generale Carlo Alberto Dalla Chiesa Park*) where the *Nascosala* had been situated, with support from a local health institution. *Stanzetta* (which translates as 'little room') is a peer operated SIF supervised by professionals from the *PuntOfermo* drop-in centre that is a needle-syringe programme (NSP). The *Stanzetta* and the NSP (both still on-going) are in the same building and were opened within two months of each other (July–September 2007). The building, once part of the mental health asylum of Collegno, has undergone numerous changes over the years, serving, respectively, as the asylum's morgue, a ticket office for a music festival, a squatted building, a dispensary of methadone and finally an NSP and *Stanzetta* in 2007. The *Stanzetta* has been carried out by the Department of Addictions at ASL TO3 without formal authorisation but tolerated by the ASL TO3 organisation. No specific funding was provided for the *Stanzetta*. All renovations (e.g. Painting) were made by drug users under the supervision of the NSP professionals. *Stanzetta* has not been thought as an experiment, rather as a peer operated SIF experience. Police became aware about the *Stanzetta* existence without any formal communication and, as explained below, a "tacit agreement" was established. Data on the *Stanzetta* experience, which is still on-going, are provided for the first time in this paper.

3. Methodology

This research took place during 10 years opening of the *Stanzetta* and drop-in PuntOfermo (NSP), from 2007 to 2017. Results are based on an account by the professional staff working in the NSP that is adjacent to the *Stanzetta*. NSP staff visit the *Stanzetta* daily to check the situation and intervene in the case of overdose. Inside the NSP, the staff offer mainly clean needles, naloxone and condoms, a daily meal, other addiction services and counselling. The three authors of this paper belong (or belonged) to the NSP staff. Objectives were defined for the purpose of this study taking into account the relevant literature (e.g. BCCSU, 2017; EMCDDA, 2004, 2018; Belackova *et al.*, 2017).

Objectives included making the *Stanzetta* accessible to as much of the target population as possible and creating in clients a sense of responsibility for the running of the *Stanzetta,* without having NSP staff assigning precise tasks. The venue's biggest challenge and goal is the prevention of overdose deaths by being able to intervene in case an overdose occurs. Beside this, spreading awareness regarding responsible injection practices through peer learning is another health goal. On the other side, public health objectives include reducing drug-related nuisance in the open drug scene. The aim of the paper was to assess how *Stanzetta* met its objectives. Analysis was conducted compiling narrative accounts from the NSP professional staff and conducting a simple frequency analysis of the available statistical data. Observations were collected from the NSP staff through a weekly diary based on 10 year participant observation (from 2007 to 2017) that took place since the opening of NSP. NSP opens for seven hours every day (excluding Saturday) from 10 a.m. to 5 p.m. The opening time and staff have undergone some changes over the years. *Stanzetta* data on collected syringes and overdoses as well as NSP data on given syringes, needles, condoms, naloxone, counselling, medications and number of clients attending the service were collected filling a daily sheet. The lack of peer involvement in this study should be corrected in future studies, which could also explore the peer support aspect through in depth interviews and focus groups. The peer perspective in harm reduction in Italy has been investigated in previous studies (Bergamo, 2015).

4. Results

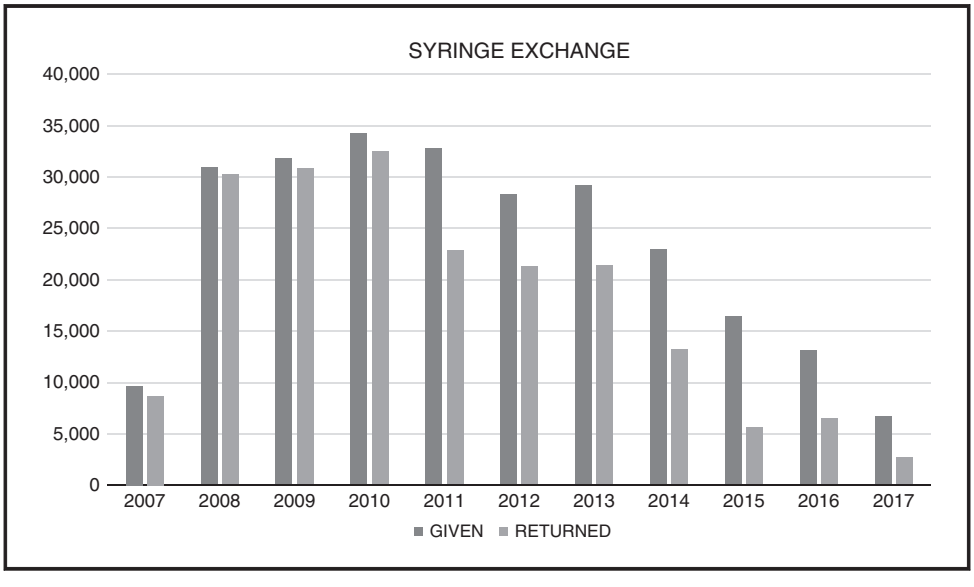
The objectives of *Stanzetta* operation were assessed with the following results.

4.1 Accessibility

The building is located in a non-residential area on the edge of the park and adjacent to a large car park. It can be reached from a bus stop located about 100 m away. Moreover, due to its location, clients cannot be seen entering the building by people hanging out at the park. The *Stanzetta* has an entrance separate from the NSP so that it is accessible regardless of the presence of the professionals operating in the NSP and open 24 hours a day. That means the discrete Stanzetta space is accessible anytime to drug users and in some hours, especially during the night, no one is there. There is a light during the night and a hole in the wall through which syringes can be deposited in a special container located inside the NSP (Figure 1).

NSP has remained opened on average 300 days per year, whereas the *Stanzetta* has remained opened every day except from November 2014 to early March 2016, when it was closed due to a fire.

Figure 1 NSP given and returned syringes



During the time when *Stanzetta* was closed, the NSP staff perceived that the duration of clients' stay in the NSP was much shorter (Table I).

During the about 10 years of study (from September 2007 to June 2017), the NSP has hosted about 493 clients, 407 men (82.6 per cent) and 86 women (17.4 per cent). Some of these clients used the *Stanzetta* more or less regularly over time. The sum of NSP daily contacts with clients is 65,614: about 93 per cent is represented by men and 7 per cent by women. Although the fact that the *Stanzetta* was self-managed and kept open for 24 h/day makes it impossible to determine the precise number and identity of clients visiting, NSP staff have estimated a total of 150–200 clients visiting it. In other words, 30–40 per cent of the NSP clients could be clients of the *Stanzetta* too. However, this estimate is only based on observations made during the opening time of NSP and no specific statistic was collected (Table II). In support of this observation is the number of returned syringes in the *Stanzetta* that amounts to 32 per cent of the total returned syringes (see Figure 2).

4.2 Self-managing

Immediately, drug users became self-empowered to run the *Stanzetta* and to keep it clean. Their daily routine consisted in accessing the NSP and taking syringes to use drugs (previously bought) inside the *Stanzetta.* They spent time inside it "enjoying the kick", usually with other drug users. After that, clients normally came back to NSP to use the sink, talk with other drug users or staff or watch TV.

Some other clients only came to use the *Stanzetta* and then they went away. Drug users who usually spent more time in the *Stanzetta* and in the NSP were those who took responsibility for cleanings and tidying and who cared much about the proper use of the place. Drug users sometimes slept on the floor and brought matrasses, carpets, bags and other objects that have been subsequently remved by the professional staff working in the adjacent NSP.

There were also occasions during the night time when the *Stanzetta* was used for illicit purposes (e.g. to extract copper from stolen electrical cables so that it can be resold), but generally, daytime use has always respected rules of coexistence. There were no shifts for cleaning work but it

Table I NPS opening and closing days

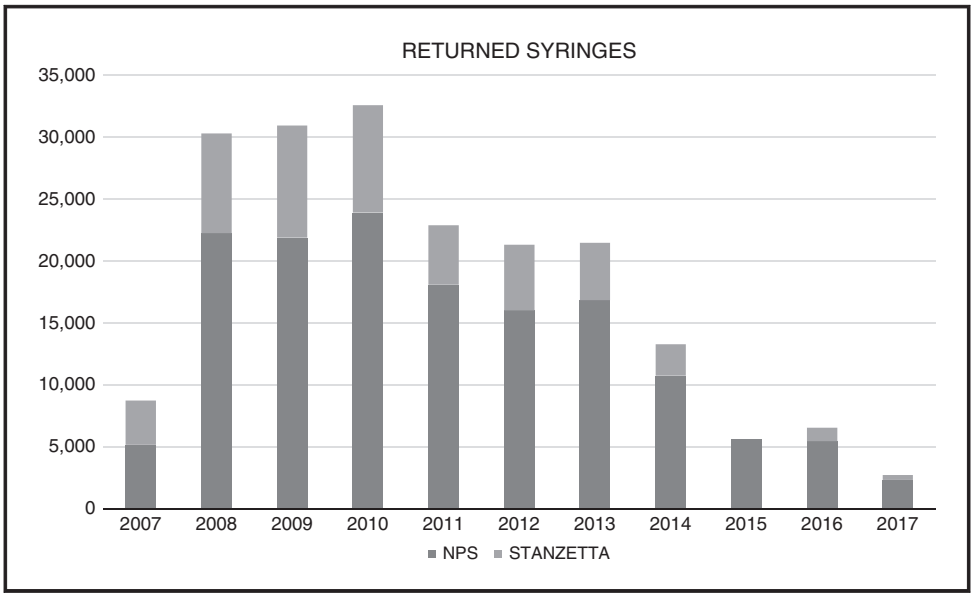
Year	*2007*	*2008*[a]	*2009*	*2010*	*2011*	*2012*[a]	*2013*	*2014*	*2015*	*2016*[a]	*2017*	*Total*
Opening days	182	313	312	312	310	287	270	270	253	252	250	3011
Closing days	25	53	53	53	55	79	95	95	112	114	115	849

Note: [a]leap year

Table II NSP clients and number of daily contacts

	Daily contacts			*Clients*		
Year	*M*	*W*	*M+W*	*M*	*W*	*M+W*
2007	1,641	131	1,772	69	8	77
2008	5,642	316	5,958	47	10	57
2009	7,070	292	7,362	47	4	51
2010	8,089	558	8,647	45	14	59
2011	8,099	687	8,786	54	15	69
2012	7,518	687	8,205	44	14	58
2013	6,427	769	7,196	30	7	37
2014	5,902	450	6,352	31	6	37
2015	4,826	206	5,032	26	3	29
2016	4,013	293	4,306	12	4	16
2017	1,909	89	1,998	2	1	3
Total	61,136	4,478	*65,614*	407	86	*493*

Figure 2 NSP and *Stanzetta* returned syringes



worked on an ad hoc basis, with cleaning materials provided by the staff from the NSP. Regular attendants even drew signs asking others to take more care about the place (Figure 2).

Between November 2014 and early March 2016, the *Stanzetta* was closed due to an accidental fire. Repairs, such as whitewashing, were coordinated by the professionals with the help of the clients. Clients themselves watched over the permanent availability in the site of naloxone and syringes for injection in the case of overdose, which means that syringes and naloxone were dispensed by the NSP and left in a box by drug users who took responsibility for asking for more in case the box got empty. Only syringes useful for naloxone injection were left in the *Stanzetta,* whereas all other syringes were provided during NSP opening time.

4.3 Overdose deaths

Although a lot of potentially dangerous injections have taken place within *Stanzetta* over 10 years, no overdose death was recorded. Professionals have intervened in 38 cases of overdose (6 of which involved female consumers) by personally injecting naloxone. It is necessary to consider that the 24-hour availability of naloxone vials in the *Stanzetta* has allowed drug users to intervene themselves in the case of overdose, even outside the opening times of the NSP (Table III).

Table III Naloxone distribution and overdose interventions

	Naloxone distribution			*Overdose interventions*		
Year	*M*	*W*	*M+W*	*M*	*W*	*M+W*
2007	43	10	53	0	0	0
2008	132	9	141	0	0	0
2009	79	15	94	2	0	2
2010	140	8	148	8	0	8
2011	213	8	221	2	0	2
2012	121	0	121	4	5	9
2013	96	8	104	5	1	6
2014	168	12	180	5	0	5
2015	35	8	43	1	0	1
2016	47	5	52	1	0	1
2017	51	16	67	4	0	4
Total	1,125	99	*1,224*	32	6	*38*

In total, 1,224 naloxone vials were delivered, of these 1,125 were distributed to men (92 per cent) and 99 to women (8 per cent). These numbers include naloxone left in the *Stanzetta* in case of need. Clients directly cared about the presence of naloxone in the *Stanzetta* and, if needed, asked the NSP staff for more.

4.4 Drug-related nuisance

Drug use in the park has shifted from more visible places (bushes, clumps of trees, meadows and walls) to the *Stanzetta*. As a result, the discarded syringes have diminished in number and those disposed off correctly have increased (Plate 1).

In the NSP, 256,500 syringes and 39,700 needles have been distributed. In total, 86,115 syringes have been delivered back directly to the professionals during the opening hours of the NSP and 46,548, more than a third of the total, in the *Stanzetta* (Plate 2).

In total, 78 per cent of the total given syringes were returned to the NSP and 32 per cent of them were given back through the *Stanzetta.* It can be assumed that, without the possibility to access the Stanzetta, about 86,000 syringes could have been discarded in the surroundings of the park. The number of syringes distributed and returned show a gradual decrease since 2010, when a peak was reached. This corresponds to the trend of the number of NSP clients and the number of daily contacts (see Table II), and the *Stanzetta* returned syringes show a peak in 2009 with 9046 syringes.

4.5 Community acceptance

Generally, good relationships were maintained over the years, along with law enforcement. In 2008, the NSP and *Stanzetta* building was found "burgled", presumably by former squatter occupants. On this occasion, for the first time, the law enforcement officers referred directly to the *Stanzetta*. After a formal complaint had been filed, the police, who came to the site to ask the professionals for information on any damage suffered by the building, referred to the *Stanzetta* in a way that meant that they knew its purpose. Thus, "tacit assent" to its existence was established. Moreover, sporadically, law enforcement officials visited the *Stanzetta* to ensure that everything was going well. Even the most frequent park goers know the purpose of the *Stanzetta*, and although they maintain some degree of mistrust, they have never complained.

Plate 1 *Stanzetta* (on the left) and the NSP (on the right)

Plate 2 Stanzetta in the inside

Nearly 10 years since the beginning of the *Stanzetta* experience, Paolo Jarre, interviewed again on 26 July 2017 stated that: "there are numerous surrogate results that are extremely suggestive of the beneficial effect of the *Stanzetta* on the whole community. The most striking is the existence, for several years, a few meters away from the entry to the *Stanzetta*, of an International Dance Centre that has hosted the most important ballet stars worldwide. Then, being more 'feet on the ground', other results are the full acceptance by all park goers, the municipal officials, the benevolent tolerance of law enforcement and, last but not least, the absence of fatal accidents for drug users and of injuries to citizens and professionals due to discarded needles[8]".

4.6 Peer support

Clients reported that better and less harmful injection practices have increased because the drug use takes place in a protected setting and therefore without anxiety linked to the fear of being seen or recognised. Drug users frequently reported the practice of risky injection taking place in the *Stanzetta* to the professionals and started debates on this between drug users. Moreover, every time someone got sick or suffered an overdose, the peers in attendance were organised to call professionals or emergency services and to not leave alone the person at risk. At times when the NSP was closed, they intervened themselves with naloxone injection and by placing an emergency call if necessary.

5. Discussion

Harm reduction policies are often contested by politicians who describe them as a form of "pro-drug use proselytism" (Jauffret-Roustide *et al*., 2013). For this reason, in Italy there is great reluctance to experiment SIFs. Efforts to establish harm reduction interventions in Italy have persisted since the mid-1990s and were undertaken primarily in response to epidemics of HIV infection and overdose (DPA, 2017). Despite this, no sanctioned SIF has ever been implemented. Activism by health professionals and local PWID has led, however, to local innovation like *Stanzetta*. Moreover, in 2017 harm reduction interventions entered the Essential Assistance Levels (DPCM, 2016, No. 40). This step was pursued by social workers, civil society organisations, NGOs and local health authorities. Considering this

background, the *Stanzetta* experience brings elements to the debate on a possible extension to Italian harm reduction policy towards a pilot SIF, whether drug user-run or health professional-run.

The *Stanzetta* provides valuable experience and points to obstacles, including laws that forbid drug possession, and thus makes drug consumption on-site at an authorised venue legally ambiguous (EMCDDA, 2004). In this respect, although regions are responsible for the administration of health care in Italy, a section of the Criminal Code (Governo Italiano, 1990) has been used at national level to argue that the operation of an SIF is, potentially, illegal. Consequently, experiences like the *Stanzetta* have remained obscure mainly for political and legislative reasons. The director of the health authority to whom *Stanzetta* belong stated: "I am still uncertain whether to make public what has happened, because still today, there's a climate where politics – both local and national – is in constant search of easy consensus (see Footnote 9)".

Primarily, this study wants to underline the urgency for an SIF pilot in Italy, and second, there is a need to consider de-medicalising these services through direct support for peer-based models considering their role in reducing drug-related risks and harms (e.g. Jozaghi and Vancouver Area Network of Drug Users, 2014; Jozaghi, 2015; McNeil *et al*., 2014, 2015). Other drug user-run experiences show that bureaucratic and legal processes can be circumvented to implement innovative intervention to reduce suffering among PWID (e.g. Bluthenthal, 1998; Kerr *et al*., 2006, 2010, 2017). The *Stanzetta* has shown limitations as well as positive implications. The hygiene-health aspect is seen as being one of the greatest challenges by the professional staff. A legal status of the service would allow some structural interventions like installing a sink or having an appropriate wall painting and floor. This experience mainly focuses on the factors concerning how to make the SIF as accessible, and manageable, as possible.

A SIF must be developed to best suit its drug-using population (BCCSU, 2017; EMCDDA, 2018; Hunt, 2006). For clients, it is very important to be not visible and have a place to use drugs away from the dangers of the street (Small *et al*., 2012). It is important that any policy decisions surrounding SIFs are made with access factor effects in mind. On one hand, these factors can limit those who wish to use the service and therefore reducing its impact. On the other hand, they can allow certain groups to improperly use the service (Hunt, 2006). Being open 24 h/days has maximised accessibility, but at the same time, it has encouraged the misuse of the *Stanzetta*. This aspect underlines the need for specific training for some PWID who can be made in charge of the proper running of the *Stanzetta.* Under their responsibility, the place could be protected from misuse. The same could be said for overdose training. SIFs allow us to protect clients from overdose (Fry *et al*., 1999; Green, 2004; Kimber *et al*., 2005; Small *et al*., 2012) and accessibility, and opening time determines the degree to which SIFs are able to have a demonstrable effect on local overdose deaths (Hunt, 2006; Lloyd and Hunt, 2007). No overdose death has ever occurred in the *Stanzetta,* but some limitations concern the lack of training for some champion peers as well as the lack of oxygen for interventions. Moreover, as syringes are not available during NSP closing time, a free-of-charge syringe and naloxone vending machine would be needed inside the *Stanzetta* to assure their availability.

To protect the service, it is important to maintain a healthy relationship with the surrounding community Creating places for drug users in order to limit open scenes has some contradictions as well with the possible emergence of residents' rejection *a priori*, as well as cases of new disturbances (Noller, 1991; Potier *et al.*, 2014; Schardt, 2001; Watson *et al*., 2012). In this respect, the *Stanzetta* has given clues of how to forge partnerships with law enforcement and citizens. Research has shown good interagency cooperation to be an effective way to minimise problems with dealing and public order (Hedrich, 2004). Numerous studies suggest that SIFs can lead to a reduction in public injecting, discarded syringes and drug-related litter (Hedrich, 2004; MSICEC, 2003; Wood *et al*., 2004). Equally, the *Stanzetta* helped reduce the number of discarded needles. This site has allowed professionals to approach drug users and the open drug scene more closely, but there is no direct observation linked to influences in micro-criminality practices. Selling in the *Stanzetta* or in NSP was forbidden, although the self-regulating nature of the place did not allow the NSP staff to be sure no selling occurred.

6. Conclusion

The results of this experience are specific to the context in which it was conducted and therefore are not generalisable. This was not a proper evaluation, but it nonetheless identifies the key issues as pertaining to the legal status and the risk of unlawfulness. Moreover, the lack of PWID-specific training led to big managing problems that cannot be underestimated. It is anticipated that many of the problems relating to monitoring, hygiene and health can be rectified once *Stanzetta* can operate as a properly regulated SIF. This peer-based SIF experience shows that PWID, when supported by health staff and safe from law enforcement, can self-organise to operate a drug consumption place that mitigates the overdose and other health risks. This model proposes the de-medicalisation of SIFs. In fact, the main finding of the paper is the acceptability of the peer-based SIF in the neighbourhood. In this regard, the *Stanzetta* demonstrated how the synergy between health professionals operating NSP and a peer-run SIF could serve as a model for SIFs in Italy. Given this clue and supported by the international evidence, it is now urgent to start a pilot SIF in Italy, whether if professional or peer-run. This need is supported by recent Italian official reports (DCSA, 2017; DPA, 2017) that show an increase in heroin trafficking and use, in particular, among young people. Moreover, the North American overdose crisis shows how essential these decisions will be if this crisis hits Europe and Italy, in particular.

Notes

1. Governo Italiano (1990) facilitating the use of narcotic drugs or psychotropic substances: anyone who uses or allows the use of a public or private premises by drugs users shall be punished with imprisonment from 3 to 10 years and with a fine from €3,000 to €10,000 if the use concerns drugs included in Tables I and II, Section A, or imprisonment from one to four years with a fine of €3,000 to €26,000 if the use concerns drugs included in Table II, Section B.
2. Collegno is an Italian municipality of 49,694 inhabitants situated in the metropolitan city of Turin and conurbated in the metropolitan area of the capital of the Piedmont Region. It is the most populous town of Torino's hinterland.
3. Interview with Paolo Jarre, Director of the Dipartimento Patologia delle Dipendenze, ASL TO3, Collegno, 10 July 2008.
4. Peer educators are active drug users or methadone taking users who collaborate in harm reduction, social support and health promotion intervention. Peer educators are widespread in the Northern Europe countries, which have a long tradition of self-organisation among drug users. Since 1995, there have been significant initiatives of this kind in Italy, especially in Piedmont, Lombardy, Liguria, Tuscany and Emilia Romagna. For more information see: P. Molinatto and S. Ronconi (Eds) (2003) Supporto tra pari e servizi a bassa soglia, EGA; M. Oldrini, L. Portis, S. Ronconi, G. Racchetti (2005), Identikit di gruppo. Ricerca su 33 operatori pari nei servizi a bassa soglia italiani, Paper, 3° Conferenza CLAT, Barcellona.
5. The project "Un parco per tutti" (A Park for Everyone) aims at cleaning up the park area in collaboration with the Sottovento outreach unit, to make the park accessible to citizens through the recovery of infected/used material.
6. It was a camping washbasin, installed so that drug users could wash their hands before and after injecting.
7. Naloxone's commercial name is Narcan®. It is used to treat respiratory depression caused by heroin or morphine overdose. It is not effective if respiratory depression is caused by substances other than opiates.
8. Interview with Paolo Jarre, Director of the Dipartimento Patologia delle Dipendenze, ASL TO3, Collegno, 15 January 2017.

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Time to look beyond ageing as a factor? Alternative explanations for the continuing rise in drug related deaths in Scotland

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Abstract

Purpose – *The purpose of this paper is to examine the reasons and risk factors that explain the threefold increase in drug-related deaths from 267 in 1996 to 934 in 2017 in Scotland. The authors explore the known links between deprivation and problem drug use (PDU) and discuss the impact of drug policy and service provision on PDU and drug-related deaths.*

Design/methodology/approach – *Using quantitative data sets from the National Records of Scotland (NRS) for drug-related deaths registered in 2017 and data sets from the Scottish Index of Multiple Deprivation (SIMD), we produce statistical data on mortality rates relating to areas of deprivation, gender and age.*

Findings – *The data highlight the disproportionate number of deaths in the most deprived areas in comparison to the least deprived areas and the national average. Findings indicate that one quarter of male and female DRD in 2017 were under 35. When examining the least deprived vingtile, drug-related deaths account for 2.84 per 100,000 population. Based on this mortality rate calculation, the amount of drug-related deaths are 23 times higher in the most deprived area than the least deprived area.*

Research limitations/implications – *The research design uses data obtained from the NRS and data from Scottish Multiple Index of Deprivation. Due to the limitations of available data, the research design focused on SIMD population vingtiles.*

Practical implications – *This research contributes to making unarguable links between entrenched structural inequality and increased drug-related death.*

Social implications – *This paper contributes to knowledge on the need for drug policy advisors to recognise the importance of deprivation that plays a major part in risks of problematic drug use and harms.*

Originality/value – *While several national data sets have published information by SIMD vingtile, no published research has sought to investigate the disproportionate number of deaths by population in the most deprived areas.*

Keywords *Social policy, Recovery, Deprivation, Drug policy, Drug use, Drug-related death*

Paper type *Research paper*

Introduction: contexts and background

As a leading cause of preventable death, opiate and opioid overdose is a major contributor to the worsening of survival among drug users over 45 and an increasing contributory factor in drug-related deaths. There is a clear trend of increased deaths among older people (aged over 35) with a drug problem in Scotland (Dickie *et al.*, 2017). This cohort experiences significant health problems related to their drug taking (Barnsdale *et al.*, 2016). In Scotland, drug-related deaths (DRD) averaged 500 per annum during 2006–2010, nearly 80 per cent of them opioid related (National Records for Scotland (NRS), 2014). In 2014, it was reported that Scotland has one of the European Union's highest DRD rates at 94 per million of population (NRS, 2017). This is comparable in effect size to the USA, which recorded 116 DRD per million of the population (National Center for Health Statistics, 2014). In international terms, Scotland has a disproportionately serious problem with drug misuse and DRD.

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Prevalence of problem users in Scotland

A study to produce prevalence estimates of problem drug use (PDU) has been conducted in Scotland every three years since 2000 (SPICE[1], 2018). After establishing a baseline of 55,300 in 2006, the estimated number of people (aged 15–64) in Scotland who use opiates (including illicit and prescribed methadone) and/or benzodiazepines illicitly is 61,300 (NRS, 2017). While the estimates of PDU have not increased significantly over the last decade, the incidence of DRD has (ISD, 2016; SPICE, 2018).

Drug-related deaths from 1996 to 2017

There were 267 DRD registered in 1996 in Scotland (NRS, 1997). The BMJ, in 2017, reported that DRD in Scotland doubled in 10 years between 2006 and 2016 (Iacobucci, 2017). The NRS released the DRD figure for 2017 of 934 deaths, an increase of 8 per cent from 2016 (SPICE, 2018). When comparing the total DRD across the UK, Scotland records DRD rates of two and a half times the UK average. While DRD have also increased in England and Wales, Scotland's drug death rate of 160 deaths per million in 2016 is the highest in Europe and compares unfavourably with the UK average of 60 deaths per million and the European Union average of 21 deaths per million (Iacobucci, 2017).

Three quarters of deaths (626) in 2016 were among people aged 35 or over, and the median age at the time of death was 41 years old (NRS, 2017).

Data from NHS Scotland in 2014 indicate that 60 per cent of those who died were in contact with a service in the six months prior to death. The majority of DRD in Scotland in 2016 (765 deaths or 88 per cent) were linked to heroin and opioids, benzodiazepines (including novel psychoactive substance (NPS)[2] substances that are similar in action to temazepam or diazepam) and alcohol (Hecht *et al.*, 2014).

In 2018, the SPICE briefing released by the Scottish Government indicated that DRD among older people aged 35 and over increased from 69 in 2000 to 397 in 2015.

Although males account for three quarters of these deaths, a recent report from the Scottish Government indicates an increase in the percentage of deaths among women from 19 per cent in 2002–2006 to 29 per cent in 2012–2016 (SPICE, 2018; Tweed *et al.*, 2018).

Poly-drug taking and drug-related deaths

In 2000, the ACMD documented those drugs which cause the most serious risk for overdose used in combination. These drugs are opiates (including the opioid methadone), benzodiazepines and alcohol (ACMD, 2000; NRS, 2017). This poly-drug taking is commonly reported by problem users in contact with services (Palmateer *et al.*, 2017). The intravenous route of administration of opiates is partly explained by problem users using what is available and what they can afford (McPhee *et al.*, 2013).

There has been an increase in the use of illicit benzodiazepines, which contribute to the total DRD (ACMD, 2016). The data from the NRS (2014) report on drugs found at autopsy indicate that 86 NPS-related DRD occurred, mostly among males (77 per cent). The average age of individuals was 35.8 years in 2014, lower than the overall NDRDD[3] cohort (39.1) NRS (2014). As in the overall NDRDD cohort, and similar to NPS DRD in previous years, most deaths were among those living in areas classified by the Scottish Index of Multiple Deprivation (SIMD) as among the most deprived SIMD quintile 1 (61, 54 per cent) and quintile 2 (28, 25 per cent).

The latest NRS data indicate that NPS implicated in drug-related deaths are almost exclusively benzodiazepine-type drugs, such as etizolam, and are almost always found in combination with other drugs (most commonly heroin and methadone). Data from the NDRDD for period 2009–2014 indicate that the most common combinations of drugs reported at autopsy were opiates and benzodiazepines. It is unclear if alcohol is commonly tested for in DRD.

One significant factor which may account for the rise in female DRD is the use of gabapentin (Neurontin) and pregabalin (Lyrica) which can significantly increase the risk of overdose and DRD if used in combination with alcohol (ISD, 2018; Tweed *et al.*, 2018).

Alcohol consumption among problem drug users remains under-reported and partly ignored, or misunderstood, by service providers. O'Rawe (2009), in a study of drinking levels among those on prescribed methadone, found that those on long-term prescriptions (prescribed 5 years or more) were drinking at hazardous and problem levels significantly more than those who had been newly prescribed (less than one year). The results of this study highlighted the need for service providers to be more aware of drinking levels among service users, particularly those in the long-term prescription cohort. These service users are often seen less regularly by their key-workers and may even be considered "stable" and no longer using illicit heroin. However, when drinking levels are considered, the potential risk to vulnerable individuals becomes ever greater. Pierce *et al.* (2014) in their report on mortality rates among opioid users found that that alcoholic liver disease was seven times more common in this cohort than the general population.

Vulnerable groups

In a 2010 report by the Scottish Drugs Forum (SDF), several vulnerable groups are identified. The report states that injected drug users are 15 times more likely to overdose than non-injectors. Risk of overdose is especially high when tolerance is reduced due to periods of reduced use or abstinence. People who have recently been discharged from hospital or released from prison are particularly vulnerable. Older drug users who have been using drugs for a long period of time are more likely to overdose due to health problems (SDF, 2010).

While an ageing cohort is in part explaining the overall rise in DRD from 2012 to 2017, the impact of the focus on abstinent recovery in the 2008 Scottish Government drugs strategy, cuts to funding of services, and the impact of poverty and deprivation and its relationship to the rise in DRD in Scotland is downplayed in the SDF report (SDF, 2017) and by the Scottish Government.

Deprivation

There is significant evidence that social conditions associated with deprivation facilitate initial drug experimentation and use, encourage a progression into problematic drug use and exacerbate the risks for negative outcomes including DRD (ACMD, 1998). While caution should be placed on drawing firm conclusions on the links between deprivation and problematic drug use, as problematic drug use occurs across different socio-economic conditions, deprivation can significantly increase the risk of DRD. Exploring the links between deprivation and problematic drug misuse, the ACMD notes that:

> Whatever the objective criteria which are employed to measure deprivation it is important to realise that what we are talking about here is a condition which at the same time will often exist as a potent, corrosive, subjective and personal experience. The mix of feelings are likely to include worthlessness and a sense of failure, powerless and the feeling of not being in control, alienation and apathy and loss of any role as stakeholder, the sense of lacking any hope of a personal way out or up and of there being no better future in sight for one's children. Deprivation is a psychological burden. (ACMD, 1998, p. 100)

The ACMD in 1998 recognised that deprivation is subtly connected to increased risk factors such as progression from recreational use to problematic use, the intravenous injection of drugs, health and social complications related to injecting, and being caught in the gaze of the criminal justice system. Being fined for possession, or jailed for possession with intent to supply, within the Misuse of Drugs Act (1971) creates intractable relationships between drug taking, criminality, and poverty (Hammersley, 2008), which further impacts stigma and discrimination (McPhee *et al.*, 2013).

Government responses to poverty and inequality

The Scottish Government has taken forward several policy and legislative initiatives to tackle poverty. The Scottish Government (2016) and the resultant Fairer Scotland Duty: Interim Guidance for Public Bodies (The Scottish Government, 2018a, b) have placed an emphasis on public bodies to take account of socio-economic issues when taking strategic decisions. At a local level, as part of the Community Empowerment (Scotland) Act 2015, Community

Planning Partnerships are legally bound to develop a Local Outcome Improvement Plan, as well as a locality plan to address socio-economic inequalities (The Scottish Government, 2018a, b). Although this a positive step in the delivery of public services within Scotland, there is scant mention of problematic drug use in the recent Poverty and Inequality Commission convened in 2017 (The Scottish Government, 2018a, b).

Government responses to increased drug-related death

The Scottish Government responses to drug-related deaths have included widening access to naloxone, access to opiate replacement therapies (including methadone and buprenorphine) and seeking to keep problematic drugs users at risk of overdose and death in treatment. While each of these priority areas holds the promise of at least partial success, the evidence for each of these interventions is different. We briefly focus on naloxone provision, safe injecting facilities (SIFs) and treatment contact.

Naloxone

Naloxone is used to reverse the central nervous system depressant effects of opiates. It can be administered orally, nasally and by injection (Kerensky and Walley, 2017). In a review of the efficacy of community naloxone distribution, Kerensky and Walley (2017) indicated that the evidence for its effectiveness as a prevention measure is still largely under- researched. Indeed, the evidence for the efficacy of naloxone to reduce the rates of DRD is considered weak by the World Health Organisation (WHO, 2014). The risk of overdose is highest on release from prison, after a period of abstinence, and after discharge from hospital (Binswanger *et al.*, 2007; Binswanger *et al.*, 2013). Bird *et al.* (2016) noted that international evidence from a meta-analysis of research on risk of overdose also indicates that the risk of DRD is high after release from prison (Seaman *et al.*, 1998). A pre-post study conducted by Bird *et al.* (2016) indicated a reduction in overdose rates among people released from prison who use heroin. Given that naloxone is an opiate antagonist, if opiate and opioid drugs are used in combination, such as benzodiazepines and alcohol, its efficacy to reverse overdose could be limited. In addition, at-risk groups must be in contact with a service for education on risk recognition and the avoidance and use of naloxone to be of benefit. It is acknowledged that more research is required on what happens to people who have been administered naloxone, and if the preceding withdrawal states increase the risk for DRD (Kerensky and Walley, 2017).

Safe injection facilities

While innovation in drug policy is demonstrated in policy initiatives such as take-home Naloxone, there have been challenges in introducing supervised injection facilities as an intervention in Scotland. Supervised or SIFs are specific environments where people who inject drugs can use their drug in a clean environment and have trained medical staff on the premises to exchange needles and syringes, who are in place to offer medical assistance, for example, when overdose occurs. While many countries in the world have set up these types of facilities, Scotland has yet to provide such an intervention.

In 2018 Alison Thewllis, the Glasgow Central MP, launched a Private Members Bill to amend the Misuse of Drugs Act 1971 to accommodate safer injecting facilities (Hansard, 2018), to address the significant rise of 120 cases of HIV in and around Glasgow City Centre (SDF, 2018). The Lord Advocate in Scotland rejected an amendment to the UK Misuse of Drugs Act 1971 (SDF, 2018). The issue reflects debates in the past on introducing methadone maintenance and needle exchanges. De Jong and Weber (1999), Stoltz *et al.* (2007), Milloy and Wood (2009) and EMCDDA (2016) highlighted the efficacy of SIFs, but also indicated, by their respective dates of publication, how long the evidence for such interventions has existed. These studies report declines in unsafe injecting practices, reduction in rates of HIV and Hepatitis C, decline in public injecting and needle sharing and rushed injections, which often lead to overdose and potential death.

Treatment contact

A total of 23,255 individuals (aged 15–64 years old) attended treatment services in 2012 for PDU, and were identified from multiple records by matching initials, date of birth, sex and Council area of residence (NRS, 2014). The data indicate that 60 per cent of individuals who died as a result of taking drugs were in contact with a service six months prior to death. Evidence from the NHS in Scotland indicates that 34 per cent of treatment episodes end as an unplanned discharge (Dickie *et al.*, 2017). More than one quarter (27 per cent) had been in police custody and around one in ten (12 per cent) had been in prison in the six months prior to death (Hecht *et al.*, 2014).

Women who use drugs report non-attendance at services due to child protection concerns (Broadhurst and Mason, 2013; Kenny *et al.*, 2015). Child removal often results in increased substance use among mothers (e.g. Kenny *et al.*, 2015; Wall-Wieler *et al.*, 2017).

What this information indicates is that despite prior contact with treatment and criminal justice services, many individuals are slipping through the net due to treatment not meeting their respective needs, difficulty for some in complying with achieving a drug-free lifestyle, and a lack of aftercare on release from police cells and prisons.

Introduction to the study

The Scottish Government reports that an ageing problem drug using cohort with health problems explains the stark increase in DRD in Scotland. This paper examines the DRD information from 2008 to 2017 using data obtained from the NRS. Using a quantitative method, we requested data on DRD, by year of registered death, age range and Scottish Multiple Index of Deprivation (SIMD) vingtile. Statistical tests calculating mortality rates as well as descriptive statistics were conducted using SPSS.

Methods

The National Drug-Related Deaths Database (NDRDD) was established by the National Forum on Drug-Related Deaths to collect detailed information regarding the nature, health and social circumstances of individuals who have died from a drug-related death. Since 2016, oversight of data collection and reporting has been provided by the Partnership for Action on Drugs in Scotland Harms Group. The NDRDD has sought to give background information on the increasing numbers of drug-related deaths in Scotland and holds a variety of information on individuals who have had a drug-related death. The data set includes: socio-demographic information; known substance use details, previous overdoses, details of medical and psychiatric conditions; details of the death, previous contact with services and information on toxicology and substitute prescribing.

The NRS provided the date when the death was registered, in accordance with the UK Drug Strategy definition, as applied by NRS/GROS definition (NRS, 2017). The prevalence statistics was undertaken in accordance with the agreed mortality rate calculation. The population total was based on working age adults within the SIMD vingtile reported within SIMD Scotland publications (The Scottish Index of Multiple Deprivation, 2018).

The question for this rapid review of the literature and key information supplied by NRS/SIMD data is:

- What factors explain the rise in numbers of drug-related deaths in Scotland?

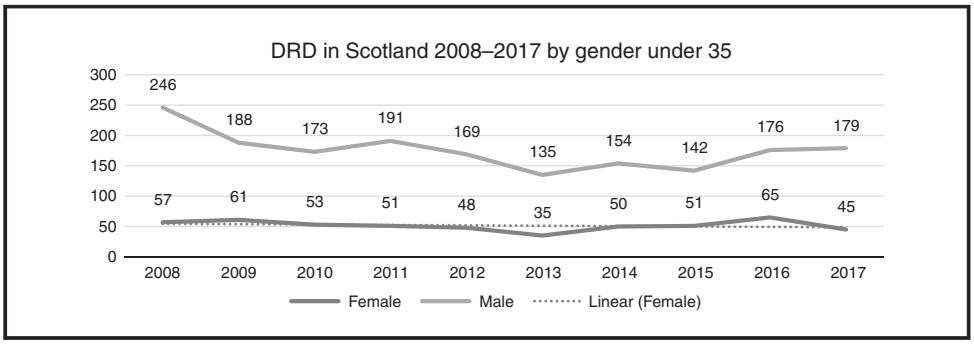
We examine the ACMD (1998) report, the ACMD (2000) report and the ACMD (2016) report. Also reviewed were Parkinson *et al.* (2017), Barnsdale *et al.* (2016), Minton *et al.* (2016), Dickie *et al.* (2017), and Tweed *et al.* (2018). The findings from the review of the NRS 2016 and 2017 data indicate several key risk factors associated with increases in DRD, unaccounted for by age-related health conditions.

Findings

Drug-related deaths in Scotland by age category 2008–2017

Figure 1 indicates that in 2008, there were 246 male and 57 female deaths, totalling 303 (53 per cent) DRD in individuals under 35. In 2017, 224 (24 per cent) of all DRD were in

Figure 1 Drug-related deaths in Scotland 2008–2017, individuals aged under 35 by gender



people under 35 (179 male and 45 female). Between 2008 and 2017, the number of DRD under 35 for females has remained relatively consistent. The data indicate that a large group of deaths of male and female individuals under 35 is not satisfactorily explained by age-related health conditions.

Figure 2 indicates that there were 391 male DRD in 2008 and 86 female DRD. There were 413 male DRD and 171 female DRD in 2017. The DRD occurring in individuals aged under 45 between 2008 and 2017, range from 477 in 2008 to 584 in 2017. While there has been a stark rise in total DRD, the death rate among females has risen significantly. It is unclear to what extent age exerts a direct causal effect on DRD risk (e.g. through a greater burden of physical co-morbidities) or is a marker for other risk factors such as poly-drug use, social isolation and complex life circumstances including issues regarding children being taken into care (Tweed *et al.*, 2018, p. 27).

Drug-related deaths by SIMD data zone

In the following tables, we produce data in the four most deprived and four least deprived vingtiles to make comparisons of the stark contrast between them. The data reproduced in Tables I–III indicated that in 2017, there were a disproportionate number of drug-related deaths in the most deprived areas, in vingtiles 1–4.

Table I indicates that 18.5 per cent of the DRDs occurred in vingtile 1, which is the 5 per cent most deprived SIMD areas. In total, 173 (18.5 per cent) of the DRD occurred within the most deprived vingtile. Conversely, only three (0.3 per cent) of the DRD occurred within the least deprived vingtile.

Figure 2 Drug-related deaths in Scotland 2008–2017 individuals under 45

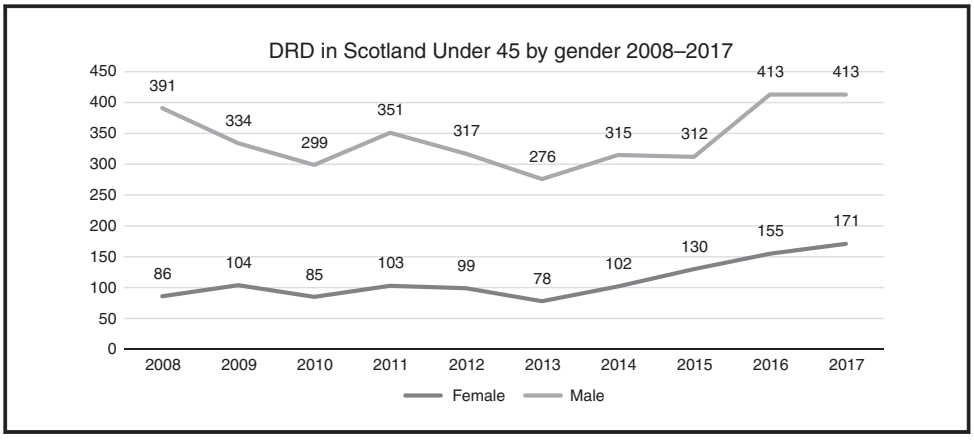


Table I DRDs in Scotland 2017 by SIMD vingtile working age population

SIMD 2016 Vingtile	*Working age population*	*Number of drug-related deaths*	*Percentage of drug-related deaths by SIMD 2016 vingtile (%)*
Vingtile 1	168,519	173	18.5
Vingtile 2	168,365	127	13.6
Vingtile 3	172,019	74	7.9
Vingtile 4	169,246	100	10.7
Vingtile 17	175,223	12	1.3
Vingtile 18	173,424	9	1.0
Vingtile 19	179,213	13	1.4
Vingtile 20	183,168	3	0.3

Note: Data calculated using UK Drug Strategy definition (as applied by NRS/GROS) obtained in April 2018 from National Records of Scotland of number of DRDs that occurred in most and least deprived vingtiles

Table II 2017 DRD mortality rate by SIMD 2016 vingtile working age population

SIMD 2016	*DRD mortality rate*	*Confidence Interval 95%*	*Drug-related deaths per 100,000 of working age population*
Vingtile 1	0.00102659	0.0009, 0.0012	102.6590473
Vingtile 2	0.000754314	0.0007, 0.0009	75.4313545
Vingtile 3	0.000430185	0.0003, 0.0005	43.01850377
Vingtile 4	0.000590856	0.0005, 0.0006	59.08559139
Vingtile 17	0.000068484	0.0001, 0.0002	6.848416018
Vingtile 18	0.000051896	0.0001, 0.0002	5.189593136
Vingtile 19	0.000072539	0.0001, 0.0002	7.253938051
Vingtile 20	0.000016378	0.000, 0.000	1.637840671

Note: Drug-related deaths mortality rate by SIMD 2016 vingtile working age population using UK Drug Strategy definition (as applied by NRS/GROS) obtained in April 2018 from NRS

Table III DRDs in Scotland 2017 by SIMD vingtile total using a whole population approach

SIMD 2016 vingtile	*Population*	*Indices*		*Confidence intervals*	*Prevalence per 100,000*
Vingtile 1	257,742	173	0.000671214	0.0006, 0.0008	67.12138
Vingtile 2	259,943	127	0.000488569	0.0004, 0.0006	48.85686
Vingtile 3	267,615	74	0.000276517	0.0002, 0.0004	27.65166
Vingtile 4	264,014	100	0.000378768	0.0003, 0.0005	37.87678
Vingtile 17	273,600	12	0.000043860	0.0000, 0.0000	4.385965
Vingtile 18	272,085	9	0.000033078	0.0000, 0.0000	3.30779
Vingtile 19	278,159	13	0.000046736	0.0000, 0.0000	4.673586
Vingtile 20	281,209	3	0.000010668	0.0000, 0.0000	1.066822

Note: Data calculated using UK Drug Strategy definition (as applied by NRS/GROS) obtained in April 2018 from NRS

Table II indicates that based on working age population, the data calculated indicate that there were 102.66 deaths per 100,000 population. Using the same methodology, DRDs in the least deprived vingtile in 2017 were 1.64 per 100,000 population.

When calculating the DRD rate per 100,000 of working age population, there were 102.66 DRDs occurring every 100,000 population within vingtile 1, which is the most deprived area.

This indicates that there were between 59 and 102 DRDs per 100,000 of working age population occurring in the most deprived areas, vingtiles 1–4. This is in stark contrast of between 1 and 7 deaths occurring in vingtiles 17 to 20, which represent the least deprived areas in Scotland. These figures illustrate the stark difference in mortality rate between the most and least deprived areas.

Table III provides data calculated using a whole population approach utilising WHO methods to obtain the burden of disease calculation. Using the WHO method, data in Table III indicate that there were 67.12 deaths per 100,000 population in the most deprived SIMD vingtile. Conversely, in the least deprived SIMD vingtile, there was 1 DRD per 100,000 using a whole population approach.

To put this data into a wider public health context, the WHO's (2015) Global Health Observatory Top Ten Causes of Death rank the leading causes of death per 100,000 population as ischaemic heart disease (119 per 100,000 population), and second highest cause of death is stroke (85 per 100,000 population). When adopting the same "whole population" methodology, DRD in the 5 per cent SIMD vingtile account for 67.12 deaths per 100,000 population in 2017. This figure highlights the strong relationship between DRDs and deprivation. When examining the least deprived vingtile, DRD account for 1.07 per 100,000 population in 2017.

Discussion

Our results indicate that a significant number of DRD occur among individuals under the age of 35. Furthermore, a disproportionate number were in the most deprived SIMD vingtile, as opposed to every other SIMD vingtile. The findings relating to age challenge the assertion that age-related health conditions are responsible for increased drug-related deaths.

There is persuasive evidence that drug problems during the 1980s became increasingly associated with social disadvantage (Pearson, 1987; Pearson and Gilman, 1994). Research to support this contention came from Glasgow (Haw, 1985; Shaw *et al.*, 2007). In 2003–2004, the rate for general/acute drug-related hospital admissions was 15 per 100,000 population for the least deprived quintile, and 240 drug-related hospital admissions per 100,000 for the most deprived quintile.

In 2015/2016, the rate of general/acute drug-related hospital admissions in the least deprived quintile had increased to 27 per 100,000 population. During the same period, the number of general/acute drug-related hospital admissions in the most deprived quintile had increased to 448.7 per 100,000 population (NRS, 2017). Dr Laurence Gruer (one of Scotland's leading authorities on drug injecting and HIV) and his colleagues noted that the relationship between deprivation and problematic drug use hospital related admission is far stronger than any other health related variable they studied (ACMD, 1998, p. 108). They also found a very strong correlation across post-code sectors between rates for drug-related and alcohol-related admissions (correlation coefficient 0.94 or $p < .001$).

Parkinson *et al.* (2017) discussed DRD between 1979 and 2013 and suggested that deprivation is significantly correlated to the increased risk of DRD in the cohort involved in their study. They also suggested that the macroeconomic policies of the 1980s may be a factor on the number of DRDs. Although Scotland suffered as a result of the decline of heavy industry in the 1970s and 1980s due to the neo-liberal economic policies of various UK Governments, other areas within the UK were subjected to the same macroeconomic policies. These areas have also seen increases in DRDs; however, they have not been at the significantly high levels recorded in Scotland. In 2012, Audit Scotland published the "Health Inequalities in Scotland Report" (Auditor General for Scotland, 2012), which suggested that health inequalities have continued to increase since devolution, indicating that health inequalities are intractable and structural, and appear resistant to short-term policy initiatives.

Warnings about the potential effects of deprivation on the health of people who use drugs have been documented (MacGregor and Thickett, 2011; ACMD, 1998; ACMD, 2016). The Scottish Government acknowledge that:

> There are strong and clear links between: poverty; deprivation; mental health and wellbeing; health inequalities; repeat offending; victimisation; and drug addiction. […] Addressing wider inequalities such

> as housing, income, education and health can play an important role in reducing drug misuse. Tackling drug misuse effectively will, in itself, have a significant impact on inequalities in Scotland (SPICE briefing paper, 2018).

However, while acknowledging the structural factors that affect the risk of PDU including poverty and deprivation, this statement suggests that tackling drug misuse will affect inequality. The Scottish Government recognises that people with serious problems with drugs are often the most vulnerable and marginalised in society and experience stigma, discrimination and social isolation. While drug use among the general adult population and among the young is falling, the risk of DRD remains highest among individuals who reside in areas of multiple deprivation.

The drug policy context

In the early 2000s, with increasing DRDs linked to methadone, a focus on abstinent "recovery" was considered the answer to address risk factors associated with problematic drug use (Ashton, 2008). In addition, there was growing support for abstinent recovery within treatment services (Duke *et al.*, 2013). In 2006, researchers claimed that under 10 per cent of males and females were achieving abstinence after 33 months of treatment. The findings indicated that almost six in ten wanted to be abstinent, while fewer than one in ten achieved it (McKeganey *et al.*, 2006).

The formation of Alcohol and Drug Partnerships (ADPs) in the mid-2000s introduced a range of statutory bodies to address problematic drug and alcohol use. This change of strategic focus was exemplified when the Scottish Government published, in May 2008, "The Road to Recovery". At its launch they defined recovery as:

> […] a process through which an individual is enabled to move on from their problem drug use, towards a drug-free life as an active and contributing member of society […]. (The Scottish Government, 2008 chapter 3:81, p. 23)

The Road to Recovery (The Scottish Government, 2008) set out a new drug treatment strategy for Scotland that emphasised a drug-free lifestyle as its central tenet. Advocates of recovery adhered to a model that advanced abstinence-based treatments rather than conventional evidence-based harm reduction strategies such as methadone maintenance therapy (MMT) and other opioid replacement therapies (ORTs) (Ashton, 2008; Duke *et al.*, 2013). William White, a prominent campaigner in the USA, promoted the idea that existing services were not equipped to enhance the collective condition of problem drug users and that new recovery groups, formed by and run by those who had lived experience of drug problems, should lead the way forward in drug treatment and recovery. He predicted a potential existential threat to professional treatment agencies when writing:

> Recovery as an organizing concept poses financial and ideological threats to existing social institutions and professional roles that have been granted cultural authority to manage AOD[4] problems. (White, 2007, p. 230)

In Scotland, prominent politicians and some academics added their voices to the criticisms of MMT and other ORTs (Ashton, 2008; Duke *et al.*, 2013). This legacy continues to influence drug treatment strategies in Scotland:

> In the last 20 years, the recovery movement in alcohol and other drugs has emerged as a major influence on alcohol and drug policy and practice in the UK, US and Australia. (Best *et al.*, 2017, p. 1)

This comment highlights the ideological shift from harm reduction towards abstinence-based recovery (McKeganey, 2011). The advocacy of a recovery model that opposes a professionalised treatment strategy and highly skilled workforce had the effect of paving the way for Government financial cuts to services.

Cuts to services in Scotland

Responsibility for treatment, support and other service provision is devolved to Scotland's 30 ADPs, formerly Alcohol and Drug Action Teams, to commission treatment services to address drug problems in their area (Audit Scotland, 2009; Davies, 2017). In 2016, the Scottish

Government cut funding to local services by 22 per cent, a reduction in funding that was maintained in 2017–2018 (SPICE, 2018). The published figures for funding for NHS and ADPs in Scotland indicate a 20 per cent cut from £69.2m in 2015–2106 to £53.8m in 2016–2017 (Davies, 2017, p. 35). Indeed, these cuts are in direct contrast to the Scottish Government's own recommendations. In 2011, it published a review of future public service delivery, commonly known as The Christie Commission, with its Chair Dr Campbell Christie stating:

> We must prioritise expenditure on public services which prevent negative outcomes from arising. (Scottish Government, 2011, p. vi)

It is clear that increased numbers of DRDs represent a negative outcome. However, the Christie Commission was short on specifics and mentioned the Scottish drug situation only fleetingly predicting that:

> The pressure on budgets is intense and public spending is not expected to return to 2010 levels in real terms for 16 years. (The Scottish Government, 2011, p. viii)

Cuts to services that provide wide-ranging treatments and support to drug users in areas where drug problems are exacerbated by multiple deprivation and poverty are exactly those areas where disproportionate numbers of problem drug users reside. In addition, cuts to services impact on what can be made available to problems drugs users. Tweed *et al.* (2018) noted that:

> Lack of funding was felt to create high thresholds for support that meant that services could only deal with individuals in crisis, rather than on a more proactive basis, and to favour services with lower paid and therefore less skilled or experienced staff. (Tweed *et al.*, 2018, p. 46)

In England, recent increases in deaths have been greatest among most deprived areas, which are also those which have had the greatest reductions in local authority funding and working age adult welfare benefits. Local stakeholders for the Public Health England (PHE) report on drug-related deaths also highlighted delays or withdrawals in benefits, which not only have a direct impact on individual health and substance use but may be followed by lump sum repayments that exacerbate short-term risk (Public Health England, 2017). Universal credit, which is a reserved matter, will likely have a significant impact on rent arrears, court-led repossession and landlord-instigated evictions in Scotland.

Conclusion

To establish that a statistical association can legitimately be interpreted as indicative of underlying causes is always difficult. Within the traditions of epidemiology, it is accepted that the stronger the observed relationships and the more often the connection is observed in different circumstances and at different times, the greater is the likelihood of causation. We believe that these criteria are reasonably well met in relation to deprivation and drug-related death.

The Road to Recovery (The Scottish Government, 2008) heralded a paradigm shift in how drug use would be addressed, with a clear emphasis on abstinent recovery. Although this new approach has seen a shift in service provision, there is little emphasis placed on the impact of deprivation, which the SIMD data provide.

Although the suggestion that older drug users die as a result of prolonged problematic drug use (Parkinson *et al.*, 2017; Scottish Drugs Forum, 2017; The Scottish Government, 2018a, b) is valid, we assert that other risk factors are significant. Parkinson *et al.* (2017) suggested that neo-liberal economic policies, emerging in the UK during the 1980s, explain the significant rise in DRDs among the older cohort. However, as we have stated, our data indicate that a significant percentage of drug-related deaths are under 35. These individuals only became of working age (16 and over) on, or after, the advent of Scottish devolution, when economic policy and the new Scottish drug strategy were under the auspices of the Scottish Parliament.

Our data indicate that problem drug users are overrepresented in areas of deprivation. This suggests that the increased risks of poor health and vulnerability to wider economic trends and welfare reforms (such as universal credit, changes in disability living allowance, its impact on rent arrears, landlord-led evictions and homelessness) have had, and will continue to have, a negative impact on the health of problem drug users and increased risk of drug-related death.

When examining DRDs by working age population in the most deprived vingtile, this compares to the mortality rate for heart disease calculated using the WHO Burden of Disease methods (NRS, 2017; World Health Organisation, 2015). The disproportionate number of DRDs in the four most deprived vingtiles is clearly a public health emergency. We contend that this would be the case if the cause of death was not due to the use of illegal drugs among the poorest individuals in Scotland.

National policy makers, as well as local service delivery partners, must address this public health emergency before it becomes entrenched, intergenerational and post-code specific. Service providers offer a range of services, however, abstinent recovery, which underpins the Scottish Government drugs strategy, should no longer remain the main focus of service contact. The figure of 34 per cent treatment episodes ending as an unplanned discharge is concerning (Dickie *et al.*, 2017). It is essential that if drug use is now under the realm of Public Health in Scotland, then relapse into illicit drug use is not considered as a failure, but a stage in a process of remaining healthy and, more importantly, alive.

Notes

1. Scottish Parliament Information Centre.
2. Novel psychoactive substances.
3. The National Drug-Related Deaths Database (NDRDD) collects detailed information regarding the nature, health and social circumstances of individuals who have died a drug-related death.
4. Alcohol and other drugs.

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Silent deaths: a commentary on new mortality data relating to volatile substance abuse in Great Britain

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Abstract

Purpose – *The purpose of this paper is to provide a commentary on new information from the Office for National Statistics (ONS) on deaths caused by volatile substance abuse (VSA) in Great Britain which occurred between 2001 and 2016.*

Design/methodology/approach – *Comparing the new study with previous mortality data, the authors consider the strengths and some limitations of the analysis provided by ONS.*

Findings – *By utilising a broader range of codes and collating additional information from death certificates, the new report provides a more comprehensive measure of VSA mortality than was previously available, showing increasing prevalence of deaths. The age profile of people dying is older than in previous studies. Most deaths were associated with inhalation of gases and almost three-quarters of deaths involved volatile substances alone.*

Practical implications – *Understanding VSA mortality is essential for service planning. It is important that we identify why so many people whose deaths are associated with VSA are not accessing treatment, with particular concern about treatment access for those who only use volatiles. Training to support drug and alcohol and other health service staff to respond to VSA is essential. In future reports, data to identify socioeconomic correlations of VSA deaths would enable targeted responses. Additionally, information on whether deaths occur in long term rather than episodic or one-off users could enable risk reduction education.*

Originality/value – *This paper shows how data on VSA deaths may inform for policy and service planning.*

Keywords *Death, Mortality, Gases*

Paper type *Viewpoint*

Introduction

A new analysis by the Office for National Statistics (ONS) of deaths caused by volatile substance abuse (VSA) or "solvent abuse" in Great Britain should encourage us to think again about this neglected form of psychoactive substance misuse.

There is frustratingly little data on VSA, defined by the EMCDDA as "the deliberate inhalation of volatile compounds to produce psychoactive effects". The last prevalence survey of adults in England and Wales (Hoare and Moon, 2010) found 57,000 16 to 59-year-olds to have used "glues, solvents, gas or aerosols" within the past year and 17,000 within the past month. The numbers were very much in line with VSA data from the preceding ten years; while the substances involved may change, the one constant with VSA is its unobtrusive persistence. It may even be on the rise: 2016 prevalence data of young people in England records a 51 per cent increase in the past-year use of "glue, gas (butane, lighter refills), aerosols or solvents" among 11 to 15-year-old from 2.9 per cent in 2014 to 4.4 per cent – and this is before factoring in poppers (0.6 per cent) and volatile substance-of-the-moment, nitrous oxide (4 per cent) (NHS Digital, 2017, Table 9.6c). As a comparator, cannabis use increased by 18 per cent from 6.7 to 7.9 per cent.

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In terms of mortality, deaths where the underlying cause is VSA are not currently included in the annual "Deaths related to drug poisoning in England and Wales" report from the ONS or the "Drug Related Deaths in Scotland" report compiled by the National Records of Scotland (NRS). The reason for this has historically been attributed to the accuracy of the data: as Stephen Penneck, then Director General of the ONS, explained in 2011: "the figures presented [by the ONS] are not the total number of deaths involving volatile substances" as "deaths associated with volatile substance abuse are under-reported in official statistics based on death registration data" (Hansard, 2011).

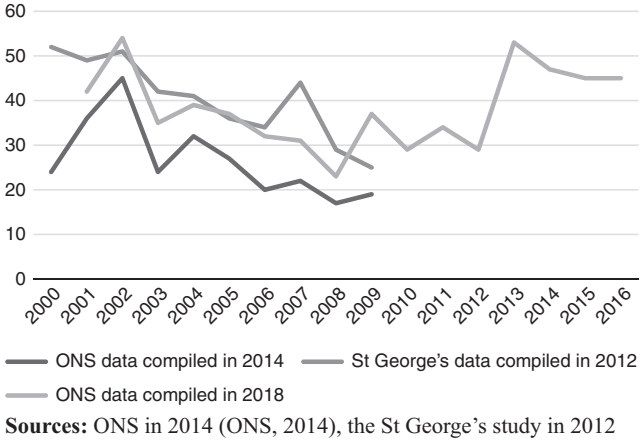
All credit to the ONS then for their decision in 2017 to tackle this problem. A re-analysis of their own mortality data for England and Wales, together with data provided by NRS (regrettably, this report does not include Northern Ireland), has led to the new report "Deaths related to volatile substances and helium in Great Britain: 2001 to 2016 registrations" (ONS, 2018b). This report indicates a generally upward trend in VSA deaths over the time period. To the already grim toll of drug poisoning deaths registered in 2016 should now be factored in 64 deaths from VSA: 45 in England, 13 in Scotland, 5 in Wales and one non-resident death.

Drawing on Re-Solv's many years' experience in advocating on issues related to VSA, we provide a commentary on the contribution of the ONS data to understanding VSA in Great Britain. We argue that comprehensive mortality data are critical to optimal policy and service planning.

Changes in the reporting of VSA mortality data

Mortality data for VSA have been the subject of some debate in recent years. Until 2012, St George's, University of London, was funded to publish the internationally regarded series of reports titled "Trends in UK deaths associated with abuse of volatile substances". Critically, St George's used not only ONS data drawn from death certificates and systematised under International Classification of Diseases (ICD) codes. In addition, the St George's team proactively requested and collated data from HM Coroners in England and Wales, from the Crown Office and Procurator Fiscal Service in Scotland and the Coroners Service for Northern Ireland – the objective being to record deaths that "occurred directly or indirectly as a result of the deliberate inhalation of a volatile substance (gas, aerosol propellants, solvents in glue and other solvents) to achieve a change in mental state" (Butland *et al.*, 2013, p. 385). As can be seen in Figure 1, incorporating data from Coroners' reports had a significant impact on the mortality data since the St George's data set could include "cases where there is no direct toxicological proof,

Figure 1 Comparison of deaths caused by VSA in England recorded



Sources: ONS in 2014 (ONS, 2014), the St George's study in 2012 (Ghodse *et al.*, 2012) and the ONS in 2018 (ONS, 2018b)

but circumstantial evidence of varying grades suggests that these deaths were associated with volatile substance abuse" (Ghodse *et al.*, 2012, p. 4). This meant that St George's generally identified higher VSA mortality than the ONS could identify from death certificates alone, as can be seen here in the comparison of St George's (red) and 2014 ONS (blue) data.

Figure 1 also demonstrates the impact of the ONS's new approach (grey) to collating VSA mortality data in 2018. This differs in two key ways from earlier ONS reports. First, although it does not entail collating Coroners' reports, a rigorous, manual investigation of the additional information available on death certificates has now been carried out. (It should be noted that data provided by NRS are rigorously collated through a slightly different process: "Drug-related deaths are identified using details from the death registrations supplemented by information from a specially designed questionnaire, which is completed by forensic pathologists and lists the drugs and solvents that were found" (NRS, 2018b, p. 9)).

Second, both ONS and NRS data draw on a wider range of ICD codes than those used to collate the annual "Deaths Related to Drug Poisoning in England and Wales" report and include gas poisonings and assaults. Both the ONS (2018a, b, c) and NRS (2018a, b) suggest that the figures are likely to be an over-estimate. The ONS estimate 4 per cent of deaths to fall into the category "where volatile substances were involved but the death would not be deemed due to substance abuse (e.g. death due to using a volatile substance without proper ventilation)". NRS are more cautious; in analysing their own data, they also suggest that there may be occasions when the volatile substance "did not actually cause (or contribute to) the death" and occasions when the volatile substance may have contributed to the cause of death along with other substances and "the person would have died from the effects of those substances, even if he/she had not abused a volatile substance".

Clearly, the new ONS report does not do everything the St George's report did – and the termination of that data set, painstakingly built up over so many years, is regrettable. Nevertheless, for national VSA charity, Re-Solv, starved of statistics but with a mission to keep VSA on the public agenda, the new report is something of a breakthrough and brings the official recording of VSA deaths more closely in line with their anecdotal sense of what is really going on.

It is possible that producing the 2018 VSA deaths report has prompted a step forward for the wider collation of drugs data and that the ONS' recent decision to carry out an experimental "deep dive into Coroners' records" relating to 2014 and 2015 drug misuse deaths was influenced by the experience of researching this new VSA report (ONS, 2018c).

VSA deaths and age profile

The key surprise in the new report for many is that VSA is no longer just about young people. In 2001, more than half of VSA deaths were of young people under the age of 20. The latest report notes that, in the period 2001–2016, VSA deaths have decreased in people aged under 20 years; instead deaths are most common across Great Britain among those aged 20–39 years, with 46 per cent of VSA deaths occurring in this age group. Scotland is also seeing increased deaths in recent years among 35 to 44-year-olds (NRS, 2018b). This is the continuation of a trend detailed by Butland *et al.* who suggested that it "may be indicative of an increase in the age at which people start to abuse volatile substances or we may simply be seeing a cohort effect with those who started to abuse in childhood in the 1980s continuing to abuse in later life" (Butland *et al.*, 2013, p. 389).

Regrettably, deaths of children and young people continue to occur – Re-Solv is aware of at least three pre-teen deaths in the past two years. However, the increased proportion of VSA deaths occurring among older cohorts does challenge the traditional assumption that young people's services can be relied on to deal with VSA. Instead the data demonstrate the need for adult treatment and support services to be alert to VSA, to assess for it as part of regular practice, and to have the skills and confidence to work with clients using these substances. There is, for example, a substantial disconnect between an estimated 57,000 past-year users and the 322 adults (and 387 young people) recorded as being in English treatment services for "solvents" by the National Drug Treatment Monitoring System (NDTMS) in 2017/18 (Public Health England, 2018a, b).

The reasons for this are complex. Some will have ceased VSA after only a small number of occasions and do not require treatment. Early stage users can find VSA intensely pleasurable, offering relief from sadness and boredom, albeit with an increasing sense of dependence and other physical and psychosocial problems emerging over time (MacLean, 2005). Many find acknowledging their VSA deeply shameful. Others do not regard VSA as drug use, which further impedes treatment access (MacLean, 2008).

VSA and the use of other substances

It is likely that more people who use volatile substances are engaged with services than we think and receiving treatment for other substance use. The ONS note that some deaths involving multiple substances are included in both the VSA mortality report and the annual drug-related death reports:

> It is important to be aware that 27% of all VSA deaths involve more than one substance (volatile or otherwise) and/or alcohol. On the death certificate it is not possible to tell which substance was primarily responsible for the death. Some VSA deaths are also counted as drug-related deaths (for example, one for which the cause of death was certified as "adverse effects of methadone, butane, propane, etizolam and phenazepam"). (ONS, 2018b)

The new VSA report notes that alcohol was also mentioned on the death certificate in 12 per cent of VSA deaths and in 21 per cent at least one other drug was mentioned. These include legal drugs such as prescription and over the counter medications, and also illegal drugs and prescription medications obtained illegally. This indicates a lower level of poly-drug use in VSA deaths than that observed in the final St George's report, which also provided a more detailed breakdown of data:

> Drugs were mentioned in 24 (54%) cases in 2009. In 2009, methadone and hypnotics (such as benzodiazepines) were both recorded in 22% of cases, followed by analgesics (pain-killers) (17%), alcohol as a sole additional substance (13%), and illicit drugs (11%). On the other hand, alcohol featured in 37% of cases in 2008, followed by illicit drugs (32%), and hypnotics (24%). The presence of methadone was also evident in both years: 13% in 2008, and 22% in 2009. These findings underline the continuing emergence of polysubstance abuse. (Ghodse *et al.*, 2012, p. 20)

As well as showing the combination of substances associated with deaths, this depth of detail gave practitioners useful insight into what other substances someone inhaling solvents might also be using (recognising the absence from the data of combinations of substances not associated with death). Some information on poly-drug use involving VSA is accessible from regional treatment data: for example, NDTMS adult treatment data in England (excluding secure settings) suggest that approximately 35 per cent of solvent users presented with an opiate/opioid and 37 per cent with an alcohol dependency in 2017/18 (Public Health England, 2018a, p. 18) and practitioners might access similar local and organisation-specific data. What we can also do is try and understand why someone might use solvents alongside another substance and what purpose the gas (or whatever volatile substance it is) is fulfilling for them.

In some cases this is apparent. For example, cigarette lighter refill cans are handy to have around if you are smoking heroin or crack and, as a depressant, butane will numb the negative effect of, for example, a crack cocaine crash or heroin/alcohol withdrawal. So if someone is using these substances it would always make sense to ask about secondary butane use.

Butane and other volatiles can also be cheap and accessible options if a preferred substance is not available – or if money is tight: some discount stores' continuing insistence on selling cigarette lighter refills from the shop floor is not only irresponsible from an ethical perspective but ideally positions cans for shoplifting. People who have used volatile substances complain that temptation to do so again is ever-present as they are continually exposed to opportunities to acquire these products (MacLean and d'Abbs, 2006).

Routine drug tests do not pick up volatile substances so they can be a useful alternative to carry someone through a period of drug testing. And people are not necessarily trying to fool the system: there are users who have chosen butane in order to stay drug-free on leaving a secure setting – butane is legal; in many users' minds, it is not a drug, more of a management tool.

Put simply – and sidestepping the issue of instant death – volatile substances can be practical, a realisation encapsulated for Re-Solv recently by a street-sleeper noting that butane is a useful substitute for alcohol if you want to remain intoxicated but have found your space for the night and do not want to leave it to urinate. Others report using volatiles to feel warm when sleeping rough.

Clearly, as evident in research literature, stigma remains an issue for VS-users (MacLean, 2008). Re-Solv is aware of clients who use a different, perhaps more "acceptable" substance, during the day and switch to gas when they are alone in the evening. So the need for a sensitive, effective approach to better assessment is critical – not just within substance misuse services but within all local support services where someone using solvents may seek help.

The involvement of different volatile substances in mortality

The new ONS report gives an interesting, but not entirely straightforward, snapshot of the involvement of different volatile substances in deaths (Table I).

Of most concern is butane. The report states that "over half (56 per cent) of all VSA deaths between 2001 and 2016 involved a fuel" and, looking at Table II, butane (by one name or another) is probably indicated in at least three-quarters of these.

Table I Number of volatile substance abuse-related deaths where selected substances were mentioned on the death certificate, deaths registered in England and Wales, 2001–2016

Substance category	*Number of deaths*	*Percentage of all VSA deaths*
Fuels	366	56
Nitrogen related	79	12
Aerosols	45	7
Specified solvents	39	6
Anaesthetic	34	5
Alkyl nitrites	18	3
Other volatile substance – specified	10	2
Volatile substance, unspecified	68	10

Source: ONS (2018b, Table 5)

Table II Number of deaths related to volatile substance abuse, where specific substances were mentioned on the death certificate, England and Wales, deaths registered in 2001–2016

Substance category	*Specific substance*	*Number of deaths where the substance is mentioned*
Fuels		
	Butane	191
	Propane	68
	Lighter Fuel	47
	Lighter gas	38
	Gas	22
	LPG	14
	Hydrocarbon	5
	Petrol fumes	5
	Fuel gas	3
	Other specified fuels	4

Source: ONS (2018b, Table 6)

Add in "aerosols" (the propellant in which is likely to be butane) and already over 50 per cent of deaths are butane-related. The number could be higher; if anecdotal evidence is anything to go by it does not seem unreasonable to assume that a good proportion of both "LPG", "fuel gas" and "volatile substance, unspecified" are also deaths caused by butane inhalation. The St George's authors also concluded that gases were associated with the majority of deaths, finding that "butane from all sources, including aerosol propellants, accounted for 74% of VSA deaths" in 2009 (Ghodse *et al.*, 2012, p. 1). Certainly, calls to Re-Solv's helpline are almost exclusively from people who are struggling with butane and using either cigarette lighter refills or aerosols. These latter tend to be personal care products such as deodorants; there is not the problem in the UK with computer dust-off that is seen, e.g., in the USA – probably for reasons of cost.

Propane is very rarely, if ever, cited by callers as a preferred substance and yet it accounts for at least 10 per cent of deaths in the report. It is difficult to draw any conclusions from the data provided, other than to question whether prevalence is considerably higher than Re-Solv is aware of, or whether the means of use is disproportionately dangerous. It would be interesting to be able to explore the specific ICD codes relating to propane deaths for additional insight here.

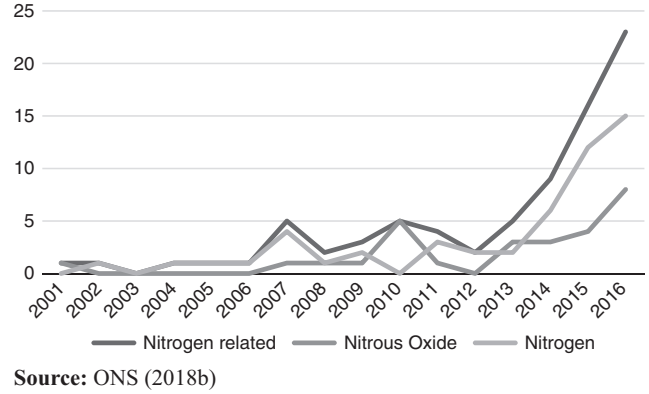
While fairly reasonable conclusions can be drawn from the report about the dangers associated with butane, the area of "nitrogen" use is a little greyer. After fuels, the report finds:

> The next most common group of volatile substances was nitrogen-related, with 12% of deaths mentioning nitrogen or nitrous oxide on the death certificate. (ONS, 2018b)

Nitrogen is an inert gas (like helium) but, in an explanatory note, the ONS state that "mentions of 'nitrogen' have been included for completeness, as many of these may be nitrous oxide". It would be helpful to be able to delve down a little further into this data; all we know is that 43 deaths were associated with "nitrogen" over the period and 36 with "nitrous oxide" (Figure 2).

In total, 79 deaths from nitrous oxide in the period seem high. Recreational nitrous oxide use (using whippets and balloons) in no way carries the risks associated with inhaling butane. Although there are cases of chronic nitrous oxide use that have been fatal, it is very possible that some of these "nitrogen" deaths have other explanations. Having said this, an increase in mortality is not unexpected bearing in mind the rise in the recreational use of nitrous oxide over the past few years – up from 2 per cent of 16 to 59-year-olds and 6.1 per cent of 16 to 24-year-olds in 2012/2013 to 2.3 per cent and 8.8 per cent respectively in 2017/2018. In total, 60 per cent of the 79 "nitrogen related" deaths since 2001 took place in 2014–2016: 9 in 2014, 16 in 2015 and 23 deaths in 2016. Latest figures from the Crime Survey of England and Wales suggest that there has been a dip in nitrous oxide use over 2017–2018 so it is sincerely to be hoped that this will be mirrored in future mortality data.

Figure 2 Nitrogen-related deaths 2001–2016 broken down by "Nitrous Oxide" and "Nitrogen"



Source: ONS (2018b)

There will always be a period of adjustment to new substances; perhaps greater public awareness in recent years means that those registering deaths involving nitrous oxide are more likely to name the substance specifically than to have to fall back on an "other VS" registration. However, it is clear that better guidelines on how to code volatile substances on death certificates would help clarify future data – and perhaps this is something Re-Solv could usefully develop.

VSA and the problem of treatment access

If someone has experimented with solvent abuse as a child, it always remains an open, relatively uncomplicated possibility to return to. And, for some, it remains the only substance of use. What is interesting from the ONS report is the large proportion of deaths (73 per cent) where solvents were the only substance found (ONS, 2018b).

This is not to say that these people only ever used solvents. But it is interesting to consider in relation to the NDTMS data, which suggests that only about 29 per cent of those currently in treatment for VSA in England are using only volatile substances (Public Health England, 2018a). This suggests that a cohort of people who solely use volatile substances, and who appear to be at high risk of death, are not making it into treatment services. This is certainly Re-Solv's view. In "The social impact of solvent abuse" (Re-Solv and Bates Wells Braithwaite, 2017), Re-Solv identified six different "types" of solvent user: young experimental users, young regular users, high functioning adult users, adult users with unstable lives, chronic solvent users and polydrug users. Of these, a significant proportion of only the last two were assumed to be in regular contact with substance misuse services. A key finding of the report was that contact – and therefore the opportunity for effective intervention – was more likely to come from other local services such as education, mental health, housing, social care, etc.

Other than shoplifting, obtaining solvents is not going to bring a user to the attention of criminal justice services; it is not necessarily an expensive habit, and moderate use can be slotted into what would be considered "normal" life. It is likely that there are a considerable number of highly functioning butane users who are perhaps self-medicating, managing stress, having a boost at the end of the day – essentially using a legal household product to get by. Re-Solv has had clients using volatile substances to help with weight loss and clients using solvents as a means of coping with severe, long-term trauma, many of whom work, maintain family responsibilities, and whose Facebook profile would ostensibly appear as enviable as the next person's.

VSA only becomes more obvious when those fine lines between "coping" and "not coping" start to blur and people using volatile substances tend only to become visible even further down the line. The "hidden" nature of solvent abuse is perhaps even more problematic now than it was when glue was the main substance. A butane high fits neatly into an available time-slot; it is discreet, quick to use, quick to recover from – who needs to know?

What can policy and service practitioners learn from this report?

What other learning can we take away from the new report that could begin to inform both policy and practice around VSA? Clearly, as discussed above, there needs to be recognition that these substances are used by adults as well as by young people; that the products involved are legal and possession is legitimate; and that the potentially tragic consequences of their use have a significant social and economic impact. One conclusion of "The social impact of solvent abuse" report was:

> Though Re-Solv is the national expert addressing solvent abuse this is a complex and multi-faceted problem which demands an effective ecosystem of support. This ecosystem should be made up of many different factors all working in a joined-up way from prevention to recovery, as well as working holistically across a range of service types. (Re-Solv and Bates Wells Braithwaite, 2017, p. 75)

Those working in adult substance misuse services need the training and confidence to assess for VSA and to support those struggling with these substances. Equally importantly, other health and care services – and particularly mental health services – need to be aware of VSA and recognise

that they are likely to be the first point of contact for vulnerable people using these substances. Disappointingly, there is no mention of VSA in the UK Government's 2017 Drug Strategy, but it is equally true for VSA as other drugs that "effective partnership working between health and social care, the criminal justice system, housing and employment support is essential" (Home Office, 2017, p. 5). Earlier intervention and referral into trained local service provision has the potential to save lives and it is clear from the number of deaths – 64 across Great Britain, approximately the same number as for MDMA/ecstasy – that an increased focus on VSA is needed across all regions. However, in a time of ever-tightening budgets, if priority areas of work need to be identified then standardised mortality ratio (SMR) data suggest that Scotland and North East England have the highest risk of VSA death. Data from Northern Ireland would also be useful here: in the period 2000–2009, the St George's report found that Northern Ireland had the highest SMR for VSA (Ghodse *et al.*, 2012, p. 14).

More data helping to identify socioeconomic correlations of VSA deaths would be beneficial. VSA is unlikely to be evenly distributed across the population and, as with other forms of substance misuse, is likely to coincide with poverty and marginalisation. In analysing the St George's mortality data, Butland *et al.* (2011) also found 12 per cent of children dying from VSA had at some time lived in care. This information would help target Re-Solv and other services' responses in locations and populations where VSA is likely to be most prevalent.

Risk reduction also needs to be considered. The ONS data do not speak to whether deaths occur in long term or chronic rather than episodic or one-off users; in many cases, it may simply not be possible to tell. Ghodse *et al.* (2012, p. 23) found evidence of a previous history of solvent abuse in 33 per cent of deaths, "no evidence of previous volatile substance abuse" in 9 per cent, while in 58 per cent "the history was unknown". This being the case, although nothing will remove the risk of sudden sniffing death syndrome (SSDS) – and this should always be absolutely clear – a skilled practitioner can help someone who is not ready to stop using solvents by talking through practical ways to reduce other risks: trying to avoid using volatile substances while alone; not spraying directly into the mouth; not using plastic bags or masks; not smoking or lighting cigarettes around these highly flammable substances; and reducing or stopping use with other drugs.

Helping to make people's methods and circumstances of use safer could have real impact. Most deaths due to VSA occur in males – 83 per cent between 2001 and 2016. Without prevalence data, it is not possible to say whether there are simply more male users (although young people's data show a slightly higher rate among girls), whether males use more frequently, or that regular and chronic use is more common in males, but it would be short-sighted not to consider whether males might be using volatile substances more dangerously or in riskier environments. As well as the risk-increasing factors listed above, Butland *et al.* (2011, p. ii) noted "a reported possible/definite increase in physical or emotional activity prior to fatal abuse was higher among VSA deaths in males than females". SSDS can be triggered by an additional surge of adrenalin when the heart is already beating arrhythmically. For whatever reason, this risk was increased for males – although the data were insufficient to suggest whether this was due to their method, time or circumstance of use. Butland *et al.* did note that males were less likely than females to die indoors, suggesting that place of use is yet another contributory risk factor.

The data can only take us so far; it is by listening to people using volatile substances and asking them these questions that we can improve our understanding and provide better risk-reduction advice. Funding is urgently required to implement strategies where some evidence of effectiveness exists, such as family therapy, activity-based approaches and multimodal interventions (MacLean *et al.*, 2012; Nguyen *et al.*, 2016). Accurate assessment and the sharing of appropriate information – both by Re-Solv and practitioners in the field – can continually enhance our understanding and effectiveness locally and at a national level.

This learning can also benefit the manufacturers and retailers of the products abused – and their involvement is key. Because VSA involves the abuse of legitimate household products, restricting their availability is problematic. The sale of cigarette lighter refills to under-18s is prohibited and some of the more responsible supermarkets have chosen to keep cigarette

lighter refills off the shop floor and to limit sales to one can at a time. Abuse of volatile substances is also covered by the Psychoactive Substances Act 2016 and, although budgets for test-purchasing have been cut, Trading Standards are responsive when Re-Solv has evidence of inappropriate sales. Stores should discourage multi-buys of substances subject to abuse, displays and signage should not draw attention to products or promotional offers and affected products should be displayed in places where they are difficult to steal. Additionally, staff should be trained to increase their awareness that customers might be misusing products, and to understand their responsibilities when they suspect that this is the case (Sumnall and MacLean, 2018).

The focus for manufacturers should continue to be on improving product safety. Printing the "Solvent Abuse Can Kill Instantly" logo on aerosols (which, it should be noted, is voluntary, not a statutory requirement) provides a necessary safety warning but it is to be hoped that investment in technological advances, such as using compressed air rather than butane, reformulating products using less toxic or volatile components (MacLean and d'Abbs, 2006, pp. 428-30) and a commitment to effectively marketing forward-thinking initiatives such as smaller can sizes will ensure that advances in product safety continue to be made.

Finally, in terms of policy and practice, targeted prevention work remains key. Universal, age-appropriate Personal Social and Health Education (PSHE) and life-skills education in school should lie at the heart of this. In 2014, for example, Mentor ADEPIS drew up "Quality standards for effective alcohol and drug education" which were informed both by evidence drawn from literature on the elements of effective PSHE education and international evidence reviewing the characteristics of prevention programmes shown to have an impact. There is also a need to implement prevention work early enough. In 2016, 61 per cent of pupils who first tried a substance at the age of 11 or younger reported that this was a volatile substance. This means that prevention education needs to begin at primary school and support children through what can be a challenging transition into secondary.

Conclusion

Last year's rise in the number of 11 to 15-year-olds reporting VS use is deeply concerning and another reason to shake us out of VSA complacency. There are simple, practical steps forward. It would be sensible to reinsert a question about adult prevalence in the next Crime Survey of England and Wales, and to request that the detailed mortality report from the ONS discussed here be published on an annual basis with data from both Scotland and Northern Ireland. Together with annual treatment data and regular reports on prevalence among young people, this will ensure that needed, up-to-date data relating to VSA is available to inform thinking around future policy and practice. In Re-Solv, there is a national UK charity proactively garnering funding – even while statutory funds are limited – to provide evidence-based expertise, advocacy, support and training and there is a willingness from manufacturers and retailers to engage and play a positive role in a collective impact initiative. It might be overdue, but it is not too late to put VSA back on the public agenda.

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Consumer participation in drug treatment: a systematic review

Mark Goodhew, Jane Stein-Parbury and Angela Dawson

Abstract

Purpose – *It is unclear how consumer participation (CP) can be optimised to transform drug and alcohol treatment services and improve health outcomes. The purpose of this paper is to present the findings of a systematic review examining the types and benefits of activities, and the factors that facilitate CP in drug treatment services.*

Design/methodology/approach – *A structured search of four databases was undertaken to identify peer reviewed primary research literature in English. Screened articles were appraised. A content analysis was applied to examine the types and outcomes of CP and the associated factors affecting the process. In total, 16 articles were included for review.*

Findings – *A range of CP activities were identified, and benefits included increased consumer satisfaction, and improved health service delivery. Factors that facilitated the process of CP included positive attitudes of both consumers and providers and employment of people with a lived experience of drug use. However, the lack of consumer and organisational capacity, negative attitudes of providers and power imbalances between consumers and providers constrained CP efforts.*

Practical implications – *To maximise the benefits of CP in drug and alcohol treatment services, negative attitudes about CP and power dynamics between consumers and health providers need to be addressed. This can be achieved by the strategic use of strengths-based interventions and consumer led education to enhance social capital.*

Originality/value – *This is the first known review to examine the benefits and facilitators of CP in drug treatment services.*

Keywords *User involvement, Social capital, Consumer participation, Drug treatment service delivery, Professional attitudes, Strength-based interventions*

Paper type *Literature review*

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Background

Consumer participation (CP) in health care transpires when consumers are "meaningfully involved in decision-making about health policy and planning, care and treatment, and the wellbeing of themselves and their community" (ACT Government Health, 2011, p. 7). CP arose from social change in the 1960s and 1970s, and has been influenced by the Black Power movement in the USA and women's and gay liberation (Tomes, 2006). In 1978, the World Health Organisation initiated CP in health care (Shea *et al.*, 2005). This action is supported by the Declaration of Alma Ata that promotes equity and social justice in health care by ensuring people have "the right and duty to participate individually and collectively in the planning and implementation of their health care" (WHO, 1978, p. 1). There is reliable evidence that involving consumers in the delivery of health care leads to more satisfactory, safer, higher quality care and improved health outcomes (Institute of Medicine, 2001). As a result, CP has become a high priority for many governments and policy makers (Tambuyzer *et al.*, 2014) and is necessary to achieve the co-production of health care services (Batalden *et al.*, 2016).

Several governments around the world have introduced policies and guidelines to guide consumer involvement in drug treatment services. The Government of the UK was the first to legislate CP in drug treatment services and, as a result, is considered a world leader

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(Hinton, 2010). The UK collects data about CP in mutual aid engagement activities, such as peer run groups and smart recovery, that are based on the principles of cognitive behavioural therapy (NDTMS, 2016). Examples of successful drug treatment involving CP are provided in the national guidelines (Public Health England, 2015). Despite these efforts, CP in drug treatment services in the UK is "patchy and sometimes tokenistic" (Hinton, 2010, p. 25). This is because CP is often poorly resourced and not embedded into strategic objectives of the service (Hinton, 2010). As a result, services are streamlined and cannot be tailored to meet individuals' needs. Furthermore, some consumers are excluded from contributing to service delivery because they are incarcerated, or live in rural areas with poor transport and services that are geographically dispersed (Hinton, 2010).

CP has been implemented for several decades in mental health services. One review in this care context demonstrated that employing consumers within these services leads to greater consumer satisfaction and reduced hospital admissions (Simpson and House, 2002). Consumer-led services have also resulted in positive employment and accommodation outcomes for mental health consumers (Doughty and Tse, 2011).

Four reviews have explored CP in drug treatment services. The first focused on consumers' perspectives regarding provider training to determine if it is responsive to consumers' needs (Wylie, 2010). The second reviewed studies that focused on the involvement of people who use drugs in policy and programme development noting the scarcity of evidence regarding their participation on policy committees (Ti *et al.*, 2012). The third critically reviewed studies that reported results of consumer satisfaction surveys in drug treatment services (Trujols *et al.*, 2014). The fourth investigated how consumer perspectives are incorporated into surveys designed to inform service development (Hyshka *et al.*, 2017).

While these reviews are informative, gaps remain in fully understanding the factors that enable or inhibit consumers' involvement in drug treatment services. Awareness of these factors is critical to realising the benefits of consumer involvement in these services.

Levels of CP

Bryant *et al.* (2008a, b) have conceptualised the participation of consumers in drug treatment services in a hierarchical manner, illustrated as a ladder that depicts various levels of involvement (Table I). At the lower rungs of the ladder CP is classified as activities such as surveys to gain insight into consumer satisfaction with services (Bryant *et al.*, 2008a; King, 2011; Patterson, Weaver, Agath, Albert, Rhodes, Rutter and Crawford, 2009; Patterson, Weaver, Agath, Rutter, Albert and Crawford, 2009; Schulte *et al.*, 2007). At the upper end of the ladder are

Table I Ladder of consumer participation

Level	*Type of participation*	*Example of activity*
HIGH	Consumers share in decision-making activities Consumer participation is built into service's values and policies	Consumers are involved in service planning Consumers attend staff meetings Consumers participate in staff selection and performance appraisal Consumer participation is incorporated into vision or mission statement
MID	Activities that promote and support consumer involvement but ones in which consumers have non-decision-making roles	Consumers are supported to conduct their own group activities Consumers are involved in staff training
LOW	Activities concerned with providing information to or receiving information from consumers	Service displays user group publications Consumer councils provide advice as to how services and programs should run Forums are held so that consumers can express their views on service delivery Surveys are conducted that ask consumers for their opinions about how services can improve Complaints process is in place where consumers can register their complaints about service delivery

more complex activities, for example, the involvement of consumers in decisions about service planning and delivery and the selection of new employees.

There is a need to understand the factors that impact on CP policy, the ability of organisations and individuals to successfully engage consumers in all aspects of service delivery and the health and socio-economic outcomes that arise as a result. The aim of this systematic review, therefore, is to identify the types of activities that are associated with CP, their associated outcomes and the factors that facilitate or constrain CP in drug and alcohol treatment services.

Methods

Search strategy

A search of the electronic databases Medline Ovid, Embase Ovid, and Scopus and Drug Database was performed in January 2018 to retrieve peer reviewed research publications in English. One additional article was sourced from a reference list of a retrieved paper. While no date limit was applied, no literature regarding CP and drug treatment was retrieved prior to 2007. The search was conducted using the following key terms: "consumer participation", or "patient participation" or "client participation" or "user involvement" or "peer" or "empowerment" and "drug treatment" or "drug treatment services" or "harm reduction services" or "drug and alcohol services" or "substance abuse treatment centers/centres". Table II outlines the inclusion and exclusion criteria that were applied.

The initial search located 1,004 items that was reduced to 18 after removing duplicates and those that did not meet the inclusion criteria (see Figure 1).

Appraisal of studies

The criteria outlined in Critical Appraisal Skills Programme CASP (2014) were used to appraise the quality of the nine qualitative studies; two were excluded as they did not fully outline the methodology. The CASP Case Control Study Checklist, CASP Cohort Study Checklist and the Joanna Briggs Checklist for Analytical Cross-Sectional Studies (Joanna Briggs Institute, 2017) were applied to the seven quantitative studies; none were excluded.

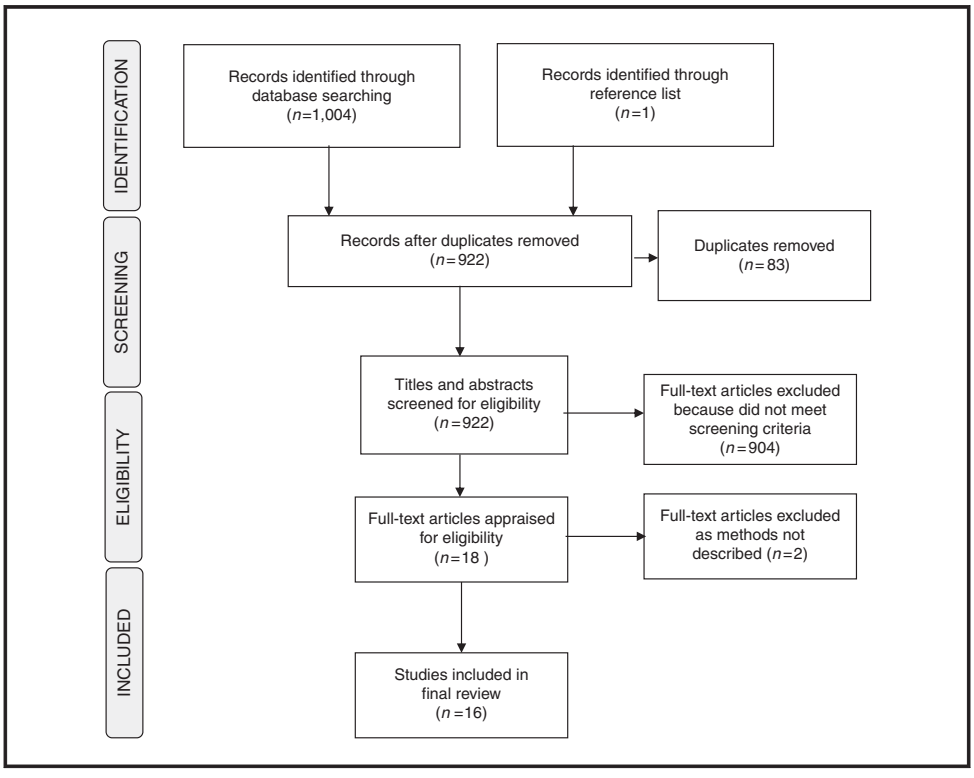
Data extraction and synthesis

Full text data were extracted from the 16 papers and first described according to general study characteristics. A directed content analysis was then employed, as outlined by Dawson *et al.* (2015), to organise the data on a table based on the CP ladder, thus enabling comparison of the findings across key areas. Activities were identified as lower, mid and higher on the ladder alongside the reported associated benefits and the factors that facilitated or constrained them. Table III outlines the characteristics and findings of the 16 studies.

Table II Inclusion and exclusion criteria

Criteria	*Inclusion*	*Exclusion*
Language	English language	Non-English language
Type of studies	Peer reviewed qualitative, mixed method or quantitative studies	Grey literature or discursive papers
Focus	Studies examining how consumers have influenced the design, implementation and evaluation of drug treatment service (e.g. detoxification, rehabilitation, opioid replacement therapy clinics and harm reduction services) and drug treatment policy through being involved in participatory activities	Studies that primarily focus on consumers delivering services to each other (e.g. peer run services), consumers providing support to each other, delivering peer education or commodities such as clean needle kits
Participants	Consumers and staff of drug treatment services	Consumers and staff of services that primarily focus on treatment for alcohol addiction or problems

Figure 1 Consumer participation in drug treatment (PRISMA) showing selection of publications for review



Results

Of the 16 studies which were included in the review, four employed quantitative research methodologies, ten used qualitative approaches and two applied mix methods methodologies. Seven of the studies originated in Australia, seven in the UK, one in Finland and one in Canada. The study sites included government and non-government detoxification services, residential rehabilitation units, opioid substitution clinics, drug and alcohol policy committees, harm reduction services and drug and alcohol counselling services.

Consumers were involved in a variety of lower to mid activities that included completing satisfaction surveys, facilitating groups, operating a café and a drop-in centre and educating providers. A range of higher-level activities was also described, including: involvement in the development of a consumer charter of rights, consumers serving as members of committees, attending staff meetings, and participating in staff recruitment, quality assurance activities, research commissioning and co-producing services.

Benefits of CP

Improved service delivery. In five studies (Bryant *et al.*, 2008b; Greer *et al.*, 2016; Patterson, Weaver, Agath, Rutter, Albert and Crawford, 2009; Tober *et al.*, 2013) service quality was enhanced when the views of service users were incorporated through consumer representation on decision-making committees, open councils or forums and service expansion projects. These improvements included: enhanced consumer-centred care (King, 2011), decreased waiting times and revised operating hours (Bryant *et al.*, 2008b; Patterson, Weaver, Agath, Rutter, Albert and Crawford, 2009), increased consumer survey response rate about service reconfiguration (Patterson, Weaver, Agath, Rutter, Albert and Crawford, 2009) and better opportunities for social support, self-help and networking (Patterson *et al.*, 2010). Consumer groups were found to support consumers through the stages of addiction and recovery by assisting them to better

Table III Characteristics and findings of articles

Author	*Participants*	*Aims*	*Method*			*Findings*							
			Quan	*Qual*	*Mixed*	*Improved service delivery*	*Increased satisfaction and goal achievement*	*Empowerment*	*Supportive attitudes*	*Employment of consumers*	*Perceptions of consumer capacity*	*Power imbalances*	*Low organisational capacity*
Brener *et al.* (2009)	492 consumers from 5 sites	Explore CP related satisfaction and goal achievement	✓				✓				✓		
Bryant *et al.* (2008a)	179 consumers at 64 drug services	Determine consumer knowledge of CP	✓								✓		
Bryant *et al.* (2008b)	As above	Determine service provider and consumers' perceptions of CP	✓			✓					✓		
Greer *et al.* (2016)	Staff and 2 consumers	Assess consumers' engagement service decision-making		✓		✓		✓	✓			✓	✓
King (2011)	8 consumers from 12 methadone programs	Investigate consumer and staff perceptions of CP		✓		✓		✓	✓	✓	✓	✓	✓
Lancaster *et al.* (2017)	41 members (7 consumers) of drug policy committees	Analyse CP discourses in drug policies		✓								✓	

(continued)

Table III

Author	*Participants*	*Aims*	*Method*			*Findings*								
			Quan	*Qual*	*Mixed*	*Improved service delivery*	*Increased satisfaction and goal achievement*	*Empowerment*	*Supportive attitudes*	*Employment of consumers*	*Perceptions of consumer capacity*	*Power imbalances*	*Low organisational capacity*
Leppo and Perala (2009)	Consumers of a needle exchange service and drug treatment service	Explore the effects of CP		✓				✓				✓	
Patterson, Weaver, Agath, Albert, Rhodes, Rutter and Crawford (2009)	139 Staff and consumers	Explore the process and purpose of CP		✓				✓	✓		✓	✓	✓
Patterson, Weaver, Agath, Rutter, Albert and Crawford (2009)	50 service commissioners, providers and consumers	Examine CP benefits and barriers	✓			✓	✓		✓	✓	✓	✓	✓
Patterson *et al.* (2010)	139 staff and consumers	Describe process and outcomes of consumer groups			✓	✓		✓	✓		✓	✓	✓
Rance and Treloar (2015)	57 consumers and staff from 3 Services	Investigate CP initiatives and the therapeutic alliance		✓				✓	✓			✓	
Roussy *et al.* (2015)	125 staff at the intervention site and 115 at the control site	Evaluate the effectiveness consumer-led training			✓			✓					

(continued)

Table III

Author	*Participants*	*Aims*	*Method*			*Findings*							
			Quan	*Qual*	*Mixed*	*Improved service delivery*	*Increased satisfaction and goal achievement*	*Empowerment*	*Supportive attitudes*	*Employment of consumers*	*Perceptions of consumer capacity*	*Power imbalances*	*Low organisational capacity*
Schulte *et al.* (2007)	46 consumers and 51 service provider	Determine consumer and provider views on the type and extent of CP		✓						✓	✓		✓
Treloar *et al.* (2011)	108 consumers and staff of 5 services	Determine level of CP		✓						✓	✓	✓	✓
Tober *et al.* (2013)	20 Mentors, 8 consumers, 6 staff, 3 academics	Describe the process of co-producing an aftercare addiction service		✓		✓		✓	✓	✓	✓		
Van Hout and McElrath (2012)	30 service providers, 12 consumers	Investigate user and provider views of CP		✓		✓			✓		✓	✓	✓

access treatment services, and by providing consumers with additional information about services, offering advocacy in the case of problems with a provider, and providing alternative forms of support for consumers who did not wish to engage in prescriptive programmes such as Narcotics/Alcoholics Anonymous (Van Hout and McElrath, 2012).

Consumer input was found to expand the current range of available services such as the development of an aftercare service (Tober *et al.*, 2013), an inpatient unit, a day programme, and mobile treatment service and the introduction of buprenorphine to increase treatment options (Patterson, Weaver, Agath, Rutter, Albert and Crawford, 2009). Consumer input also led to the development of improved harm reduction interventions, such as a take home naloxone programme and the provision of a wider range of safer inhalation supplies (Greer *et al.*, 2016) and injecting equipment (Patterson, Weaver, Agath, Rutter, Albert and Crawford, 2009).

Increased satisfaction and goal achievement. Studies revealed that consumers who participated in planning and delivering services including the type of drug treatment they wished to undertake, enjoyed high levels of satisfaction (Brener *et al.*, 2009; Patterson, Weaver, Agath, Rutter, Albert and Crawford, 2009) and goal achievement (Brener *et al.*, 2009). A survey of 492 consumers found that consumer satisfaction increased when consumers participated in planning their treatment and that this participation increased awareness of their rights (Brener *et al.*, 2009). Brener *et al.* (2009) also reported that the achievement of treatment goals was associated with being involved in a review of the service and having knowledge of grievance procedures.

Empowerment. Involving consumers in CP activities was found to foster consumer empowerment as their participation altered the power dynamics of the consumer–provider relationship (King, 2011; Patterson, Weaver, Agath, Albert, Rhodes, Rutter and Crawford, 2009; Rance and Treloar, 2015) and reduced the stigmatisation of service users (Patterson, Weaver, Agath, Albert, Rhodes, Rutter and Crawford, 2009). CP decreased the interpersonal distance between consumers and providers (Patterson, Weaver, Agath, Albert, Rhodes, Rutter and Crawford, 2009), allowing them to see each other's human qualities (Rance and Treloar, 2015) and find common ground (Tober *et al.*, 2013). As a result, consumers were able to gain confidence and a sense of ownership over aspects of the service (Patterson *et al.*, 2010; Tober *et al.*, 2013).

Consumer empowerment was affected by the ethos underpinning the health service itself. Providers who worked in harm reduction services were found to be less paternalistic than those who worked in more traditional setting such as a drug treatment service for pregnant woman (Leppo and Perala, 2009).

Health care organisations that facilitated consumer led training were found to have empowered consumers, improved relations between consumers and providers and decreased stigma and staff discrimination towards consumers (Roussy *et al.*, 2015). As a result, providers stated that they gained a greater understanding of needs of people with both substance use and mental health disorders and felt more competent in their caring role. Consumers also became empowered as members of harm reduction committees, as their membership helped them to become involved in their community, develop confidence and skills and become inspired by peer leaders (Greer *et al.*, 2016).

Consumers reported that they became more confident to express their needs through their involvement in participatory activities. One consumer expressed this by stating that "I think it is important that users have a voice 'cause we are people too' " (Rance and Treloar, 2015, p. 33). Consumers also reported this "voice" could be political in nature (Rance and Treloar, 2015), thus, invigorating their desire for social justice (Patterson, Weaver, Agath, Albert, Rhodes, Rutter and Crawford, 2009). Therefore, a voice helped consumers educate the public and raise awareness about issues that impact them (Rance and Treloar, 2015; Patterson *et al.*, 2010), such as the need for the decriminalisation of drug use, reforms in prescribing policies, and making drug treatment more accessible and respectful (Patterson, Weaver, Agath, Albert, Rhodes, Rutter and Crawford, 2009). The consumers' voice also informed the development of participatory activities that helped to create solidarity among consumers and enabled collective feedback to be presented to service providers (Patterson *et al.*, 2010).

Facilitators of CP

Supportive attitudes of consumers and providers. Eight studies revealed that the supportive attitudes of consumers and professionals encouraged consumers to be more involved in drug treatment service delivery and planning (Greer *et al.*, 2016; King, 2011; Patterson, Weaver, Agath, Albert, Rhodes, Rutter and Crawford, 2009; Patterson, Weaver, Agath, Rutter, Albert and Crawford, 2009; Patterson *et al.*, 2010; Rance and Treloar, 2015; Tober *et al.*, 2013; Van Hout and McElrath, 2012). Attitudes reflecting values that CP was fundamental to effective service delivery facilitated consumer-centred care through developing an understanding of service users' individual and collective needs (King, 2011; Patterson, Weaver, Agath, Albert, Rhodes, Rutter and Crawford, 2009). Therefore, CP was facilitated by an organisational culture that embodied optimistic views and an appreciation of consumer contributions (Van Hout and McElrath, 2012), and mutual respect (Patterson, Weaver, Agath, Rutter, Albert and Crawford, 2009) that allowed consumers and staff to work towards a collaborative ethos (Rance and Treloar, 2015).

Such organisations demonstrated these values through adequate funding and dedicated time to participatory initiatives (Greer *et al.*, 2016; Patterson, Weaver, Agath, Rutter, Albert and Crawford, 2009). Other aspects of these organisations included well-defined internal and external communication pathways (Patterson *et al.*, 2010), clearly articulated expectations (Greer *et al.*, 2016), and the provision of feedback on the progress and outcome of consumer requests and suggestions (Patterson, Weaver, Agath, Rutter, Albert and Crawford, 2009).

Employment of consumers with lived experience. Three quarters of consumers in the Schulte *et al.* (2007) study were supportive of people with a lived experience of drug use being employed on a voluntary or paid basis. Consumer employment was underpinned by the understanding that they are well-informed, have the knowledge, understanding and credibility to be effective (Treloar *et al.*, 2011) and are more empathic, as they have similar life experiences as consumers (King, 2011). The mentors who helped produce an aftercare service reported that their lived experience of recovery helped other consumers to see that it is "possible to move on [and] to learn to live again" (Tober *et al.*, 2013, p. 231).

Patterson, Weaver, Agath, Rutter, Albert and Crawford (2009) reported that people with a lived experience working in drug treatment facilities required specific training that included information about the service structure and processes and formal meeting procedures, such as agendas, chairing meetings and minute taking. It was also recommended that this training should be self-reflective, so consumers can review their learning and performance. Training ultimately helped consumer representatives progress to paid positions within drug services (Patterson, Weaver, Agath, Rutter, Albert and Crawford, 2009).

Constraints of CP

Perceptions of consumers' capacity. Service providers were reluctant to involve consumers, especially in higher-level activities, such as staff training, recruitment and performance appraisal, because they thought that consumers did not possess the skills or interest to successfully undertake such activities (Bryant *et al.*, 2008b; Patterson, Weaver, Agath, Rutter, Albert and Crawford, 2009; Schulte *et al.*, 2007; Van Hout and McElrath, 2012). Providers in the Patterson, Weaver, Agath, Albert, Rhodes, Rutter and Crawford (2009) study "questioned the legitimacy of involving people who 'choose' to use illicit substances and therefore have 'self-inflicted problems' " (p. 57). Even when active CP was embedded into services, providers expressed doubt about the sustainability of these activities as consumers were viewed as unstable, manipulative, untrustworthy, powerless, vulnerable and lacking in capacity to participate because of their chaotic lifestyles and social problems (Patterson, Weaver, Agath, Albert, Rhodes, Rutter and Crawford, 2009; Patterson *et al.*, 2010; Treloar *et al.*, 2011; Van Hout and McElrath, 2012). Fears that consumers may relapse or would endanger the recovery of those who were abstinent were also expressed (Van Hout and McElrath, 2012; Tober *et al.*, 2013). Providers were also reluctant to involve consumers in service delivery because they lacked trust in them, were concerned about their strong opinions (Patterson, Weaver, Agath, Rutter, Albert and Crawford, 2009) and disparate and unrealistic expectations about service delivery (Patterson *et al.*, 2010; King, 2011).

Consumers also expressed the view that it was not their place to be involved in staff matters because they perceived that they did not have: the necessary skills (Bryant *et al.*, 2008b; Patterson, Weaver, Agath, Albert, Rhodes, Rutter and Crawford, 2009), stability (King, 2011; Treloar *et al.*, 2011), interest, confidence or entitlement to participate (King, 2011). Peer mentors who co-produced an aftercare service reported they felt uncomfortable and confused about their boundaries when consumers disclosed information that they usually relayed to a therapist because they lacked counselling skills (Tober *et al.*, 2013). In another study, providers were worried that peer workers would disregard guidelines, interpersonal boundaries and confidentiality issues, because they lacked formal training (King, 2011).

It was also revealed consumers were unaware of opportunities to participate due to a lack of knowledge about CP in principle or in practice (Patterson, Weaver, Agath, Albert, Rhodes, Rutter and Crawford, 2009). Several studies reported that consumers did not know how to make a service complaint (Bryant *et al.*, 2008a; Brener *et al.*, 2009), nor did they know the location of the suggestion box (Bryant *et al.*, 2008a). In another study consumers and providers were unaware of the service user support team whose role was to advocate on behalf of consumers (Van Hout and McElrath, 2012).

Studies have also questioned consumer groups' capacity to represent the diverse range of people that engage with drug treatment services (Patterson, Weaver, Agath, Rutter, Albert and Crawford, 2009; Patterson *et al.*, 2010; Van Hout and McElrath, 2012). It was reported that cliques often occur in drug user groups (Patterson, Weaver, Agath, Albert, Rhodes, Rutter and Crawford, 2009), and they are perceived as "exclusive" (Patterson *et al.*, 2010). Consequently, this limits group membership, as selection of members is frequently based on therapeutic orientation, drug user status or relationship with the group convenor (Patterson *et al.*, 2010). It was proposed that service user forums need to increase their visibility to broaden their membership and include prisoners, gay, lesbian and transgender people, and migrants to ensure a more accurate representation of drug treatment consumers (Van Hout and McElrath, 2012).

Power imbalances between consumers and providers. Providers reported that they were reluctant to involve consumers in service planning and delivery because of the hierarchical professional–client relationship, described as the "them and us" divide that emphasised beliefs that health care providers know best (Leppo and Perala, 2009; Patterson, Weaver, Agath, Rutter, Albert and Crawford, 2009; Rance and Treloar, 2015). Providers were found to be resistant and concerned about moves towards establishing more equal power relationships (Rance and Treloar, 2015; Treloar *et al.*, 2011), as they feared that professional authority might be undermined. Such views were said to perpetuate negative and judgemental views towards consumers (King, 2011; Patterson *et al.*, 2010; Patterson, Weaver, Agath, Albert, Rhodes, Rutter and Crawford, 2009; Patterson, Weaver, Agath, Rutter, Albert and Crawford, 2009; Van Hout and McElrath, 2012).

Consumer representation on committees (Greer *et al.*, 2016; Lancaster *et al.*, 2017) was found to be "weighted towards scientific voices" (Lancaster *et al.*, 2017, p. 64) that maintained professional dominance in decision making. In addition, consumer knowledge was often seen as illegitimate, as it represented "the antithesis of clear and systematic reasoning" (Lancaster *et al.*, 2017, p. 65).

Power divides and conflicts between consumers and staff were reported to be intensified by abstinence-related punitive rules set by residential treatment services (King, 2011). Consumers were reluctant to make complaints against staff because they worried that staff would assert their power by restricting medication or excluding them from services (Patterson, Weaver, Agath, Albert, Rhodes, Rutter and Crawford, 2009).

Low organisational capacity. A lack of organisational direction from government and support for consumer positions that enable consumer advocacy was found to negatively affect the ability of managers to bring about change (Van Hout and McElrath, 2012). The low value of consumer support positions was also explained by inadequate terms of reference (Van Hout and McElrath, 2012), poor organisational drive and obstruction to programs (King, 2011), and insufficient commitment from government (King, 2011; Patterson, Weaver, Agath, Albert, Rhodes, Rutter and Crawford, 2009).

Other studies reported that poor allocation of financial and human resources constrained CP projects (King, 2011; Patterson, Weaver, Agath, Albert, Rhodes, Rutter and Crawford, 2009; Patterson, Weaver, Agath, Rutter, Albert and Crawford, 2009; Patterson *et al.*, 2010; Schulte *et al.*, 2007; Treloar *et al.*, 2011; Van Hout and McElrath, 2012). These studies found that CP was not considered "core business" and that projects were often disrupted because of staff resignations, poor staff hand over (Greer *et al.*, 2016; Treloar *et al.*, 2011) and organisational time constraints (Patterson, Weaver, Agath, Rutter, Albert and Crawford, 2009).

Patterson, Weaver, Agath, Albert, Rhodes, Rutter and Crawford (2009) reported that the focus on attaining performance targets, undermined the resources, energy and commitment required for CP. Staff also often under estimated the amount of work required to undertake a CP project and did not value training in this area (Treloar *et al.*, 2011).

Discussion

This review has revealed that CP has the potential to enhance drug treatment services and health outcomes. CP can increase consumer access to improved and expanded services, improve consumer satisfaction, relationships between staff and consumers, reduce individual providers' negative attitudes and help consumers achieve their treatment goals. CP activities ultimately empower consumers by giving them a voice and the skills knowledge and confidence they require to actively and meaningfully contribute. However, CP is predicated upon a service delivery context that values consumer contributions through clear commitment that is articulated in policy and resourcing.

Even though CP policy has been enshrined into agency policy, attitudinal change at an organisational level which facilitates the translation of policy into practice at service level remains a challenge. Despite the existence of CP policies at the macro level, consumer involvement in drug treatment services is constrained by organisational cultures at the micro level. Consequently, CP initiatives are often poorly conceived and inadequately resourced, especially higher-level activities. Often, attempts to incorporate higher levels activities into drug treatment service delivery are not sustained due to organisational instability, including frequent staff changes, insufficient handover of CP projects and the low value of CP as core business (Treloar *et al.*, 2011).

The notion that consumers are incapable of contributing also needs to be challenged if CP is to succeed in drug treatment services. Some providers will be reluctant to meet these challenges, as drug and alcohol services "are framed by an environment that is strongly risk averse" (The Royal Australian and New Zealand College of Psychiarists, 2012, p. 18). This is reflected in a physical environment of treatment services that are often fitted out with bullet-proof glass and buzzing doors, which reinforces the notion that consumers are associated with danger and illegal activity (Crawford, 2013). As a result, providers are often reluctant to involve consumers in service delivery because they are perceived as "criminals", "addicts" and "junkies" (Radcliffe and Stevens, 2008; Crawford, 2013; Harris and McElrath, 2012). Such conceptions of substance dependence necessitate change to improve attitudes concerning consumer involvement in service delivery.

Since the 1970s, substance dependence has been viewed through a pathological lens (Siegal *et al.*, 1995) and over the past 20 years in the American Diagnostic and Statistical Manual of Mental Disorders substance dependence has been increasingly conceptualised as biological in nature (Nathan *et al.*, 2016). Furthermore, drug treatment is dominated by programmes that claim that individuals with substance dependence are "diseased" and "powerless" (Verde Valley ArizonNA, 2014). Describing individuals with substance dependence in this manner reinforces criminal stereotypes such as the "junkie" (Crawford, 2013). In addition, stigma and discrimination restrict involvement of consumers in policy and programme development (Ti *et al.*, 2012). Overall, a purely biological/diseased and stigmatised view of substance dependence reinforces the belief that drug treatment consumers lack capacity not only to contribute to their own care but also service delivery and planning.

A strengths-based model would move beyond a focus on an individual's pathology or deficits (Rapp and Goscha, 2011) to overcome the perception that drug treatment consumers lack

capacity to participate. This model includes a systematic assessment of a consumers' skills, attributes and assets (National Registry of Evidence-Based Programs and Practices, 2009), that is based on the creation of egalitarian consumer–professional relationships with consumers' directing the helping process (Rapp and Goscha, 2011). These strategies flatten the hierarchical expert–patient relationship that dominates drug treatment services and constrains CP (Putnam, 1993). More harmonious and equal relationships help to foster an environment where the consumers' input is more likely to be considered. One way to promote such relationships is for services to invest in social capital.

Social capital, as conceptualised by Putnam (1993, p. 35), includes the "features of social organisations, such as networks, norms and trust that facilitate action and co-operation for mutual benefit". Shared connections between consumers are developed through activities such as the service user support teams (Van Hout and McElrath, 2012). Here social capital is built through the bonding of consumers. Bridging social capital or enhancing the connections between different consumers and staff in treatment services can be achieved by consumer training of staff that promotes an understanding of consumer needs and awareness of the importance of mutual respect (Roussy *et al.*, 2015), and well-defined communication channels (Patterson *et al.*, 2010). Engaging diverse groups of consumers in decision-making committees within treatment services is key to linking social capital by increasing the degree to which people create relationships with institutions and individuals who have considerable amount of power over them (Woolcock, 2001). Building social capital will, therefore, help to reduce the power differentials that constrain CP.

Harnessing the opportunities for social capital can help drug treatment organisations improve performance as teamwork is an essential element of quality health care (Norrish *et al.*, 2013). High levels of social capital are associated with improved drug treatment and harm reduction outcomes such as reduced risk of relapse (Panebianco *et al.*, 2016) and overdose (Zoorob and Salemi, 2017), recovery from substance and alcohol dependence (Granfield and Cloud, 2001; Weston *et al.*, 2018), and a decreased risk of sharing syringes (Kumar *et al.*, 2016).

In mental health care, the recovery movement has been particularly successful in supporting people who experience mental illness to gain increased levels of social capital. This has been achieved because the consumer driven nature of the recovery movement focuses on self-determination through the provision of opportunities for people with mental illness to contribute to mainstream society through work and education (Davidson, 2016). This has enabled mental health consumers to gain a voice and a renewed sense of hope (Meehan *et al.*, 2008). In the UK, drug treatment services are starting to follow by providing opportunities such as sustained employment as part of treatment (Black, 2016).

While activities to build social capital that address the treatment needs of consumers and better engages consumers in their own care are required, these will need to be tailored to fit individual contexts. The ladder of CP depicts a range of activities that can be implemented to change power dynamics and empower consumers. However, the different types of knowledge and expertise that are central to the process of consumer participation require a comprehensive approach to capacity building. In addition, not all people will desire power or want to be involved in decision-making activities (Tritter and McCallum, 2006).

Even though it is useful to depict the power dynamics at the various levels of the ladder the activities and processes in drug treatment service delivery are not straightforward or linear. This is because the different levels of activity take place simultaneously and there is a variation in the degree to which consumers are willing to participate and the activities in which they are willing to engage. Some consumers will not want to participate, as they may wish to concentrate on their treatment; some will be pleased to contribute by completing a satisfaction survey; while others will be highly motivated to volunteer their time, for example, by being a consumer representative on a committee that informs policy.

A framework for CP would be improved by visualising participatory activities in a more dynamic fashion, with participatory activities displayed in an integrated manner rather than ranked as a hierarchy as implied by the ladder of CP. This will allow reference to "bundles" of activities from all levels of the ladder to better illustrate the complexity and need for tailoring according to the context.

The ladder does not consider the full spectrum of CP. For example, it does not account for consumers who choose not to participate, and consumers who are employed in drug treatment services because of their lived experience of drug use and recovery.

Limitations

A limitation of this review is that only literature published in the English language was included. In addition, there was no literature related to closed settings such as prisons and involuntary treatment, where unequal power dynamics are exacerbated. Therefore, the synthesis may be lacking in detail, particularly in relation to contextual factors that are important to the outcomes of the various CP interventions.

Implication for research

Future research needs to focus on how current policy decisions impact upon providers attitudes towards CP and on the commissioning and monitoring of services. Therefore, it would be useful to investigate staff experience, professional development and communication skills in relation to how these factors impact on their attitudes and the implementation of CP projects. In addition, the barriers to CP for prisoners, migrants, gay, lesbian and transgender people need to be investigated.

Conclusion

Positive attitudes towards CP in drug treatment services may not evolve to successfully address consumer needs if drug treatment services do not invest in social capital. Consumers' capacity to contribute requires a supportive organisational environment that challenges notions of "staff know best", therefore, addressing embedded attitudes and power imbalances. In addition, the current ladder of CP in drug treatment needs to be transformed so all forms of participation are equally valued and increased "buy in" from strategic bodies and commissioning teams is required.

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Challenges, relationship and outcomes in low-threshold drug services

Sarah Morton and Laura O'Reilly

Abstract

Purpose – *This paper reports on the findings of an action research study that sought to explore the development and provision of community-based low-threshold services within a socially disadvantaged area. In the context of debates, in regard to both the nature and efficacy of low-threshold drugs services and increasingly neo-liberal policy approaches to drug service provision that prioritise outcomes and drug treatment interventions, the purpose of this paper is to report on practitioners' understandings of challenges, relationship building and outcomes within community-based low-threshold service provision in Dublin, Ireland.*

Design/methodology/approach – *An action research method of co-operative inquiry groups was utilised, with nine practitioners from one community-based drug agency participating in a series of four sessions over a three-month period.*

Findings – *Three key themes emerged in relation to building and sustaining client–practitioner relationships: the mechanisms by which the practitioners engaged with their clients and sought to develop relationships; how safe spaces were created and maintained in order to address client needs; and practitioners' understanding of challenges and outcomes in low-threshold intervention work.*

Originality/value – *Drawing on a co-operative inquiry method, this paper concludes that practitioner attention to relational distance evidenced in community-based low-threshold service provision, may provide an alternative to episodic, outcome driven drug treatment and intervention.*

Keywords *Relationship, Outcomes, Risk, Practitioner, Substance use, Low threshold*

Paper type *Research paper*

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Background

As in many other jurisdictions, drug policy and intervention in Ireland has undergone a significant range of changes and developments over the past decade, at a time of recessionary pressures and an increasingly neo-liberal policy context (O'Gorman *et al*., 2016). Low-threshold service provision, aimed at reducing barriers to access (Notley *et al*., 2012), is characterised by drop-in and outreach interventions underpinned by harm reduction approaches (Toumbourou *et al*., 2007). Few of these types of interventions are offered within community settings (Fursova, 2016), and there has been little attention paid to practitioner approaches. The study now described sought to explore the development and provision of community-based low-threshold services within a socially excluded urban area in Dublin, Ireland, highlighting key aspects of the skills and knowledge of practitioners and client–practitioner relationships.

Policy and treatment landscape

A number of critical commentaries have emerged about the policy and treatment context in this area of practice. Fraser (2017) argues that narratives about addiction tend to be couched in terms of the construction of medical "problems", rather than in terms of structural causation informed by narratives about poverty and social exclusion (Jöhncke, 2009). As a consequence, there tends to be a narrowing of service users' needs towards individualised paradigms of care and treatment (Moore and Fraser, 2013). Thus, "episodes of care" models can exclude other ways of understanding the lives of service users and their experiences of dependence of state benefits, homelessness or mental health problems. On the other hand, programmes and

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interventions that do not require abstinence, or that challenge the norms of the treatment model, may not only be less culturally acceptable, but an active disruption to the sense of cultural accommodation provided to the rest of the population by "treatment" (Jöhncke, 2009). It has been argued that low-threshold drug services may be important in sustaining the episode-based treatment model by rendering less visible (Langegger and Koester, 2016) those service users who are deemed unsuitable or not "ready" for mainstream treatment episodes.

Within the Irish context, policy and intervention responses to drug issues have been characterised by ambiguities in the relationships between evidence, policy decisions and ideology (Randall, 2011). Abstinence based responses are a mainstay of policy (Murphy, 1996), despite the introduction of harm reduction services involving needle exchange, methadone maintenance treatment and drop-in services (Butler and Mayock, 2005). As in other jurisdictions, drug policy in Ireland continues to negotiate difficulties in reconciling criminal and health responses and harm reduction and abstinence-based treatment approaches (Butler and Mayock, 2005). Low-threshold and harm-reduction services are presented as falling within a continuum that progresses to stabilisation, detoxification, rehabilitation and aftercare, but not as a service response in their own right (Bates *et al*., 2017). Meanwhile drug issues within some socially excluded urban areas in Ireland remain an intractable issue, particularly in the aftermath of the recent recession and subsequent funding cuts to community and drug intervention services (Citywide, 2016) and criticisms remain about perceived failures of public policy to respond effectively to the needs of individuals, families and communities in these circumstances (Butler and Hope, 2015).

Harm reduction and low-threshold service provision

Harm reduction can be defined as a set of strategies aimed at reducing the negative consequences of substance use for the user and the wider community (Marlatt, 1996). It can be considered as an alternative to abstinence-based approaches; a key principle is that by lowering or removing thresholds for supports or services for those using drugs, stigma is reduced (Marlatt, 1996, p. 787) which, in turn, provides a pathway towards drug stabilisation, reduction or further treatment (Lee and Zerai, 2010). The concept of low threshold is associated with a range of drug services that either do not require abstinence, which provide specific supports such as needle exchange, or a range of health- related supports, such as food and showering facilities (Melles *et al*., 2007). The term is also often applied to very specific services such as drug consumption facilities, supervised injecting facilities or some methadone maintenance treatment programs (Strike *et al*., 2013).

Islam *et al*. (2013) propose three criteria for the provision of low-threshold services; drug users should be a key (but not necessarily the only) target population; that abstinence from drug use should not be necessary; and that other barriers to service access must be reduced as far as possible. Low-threshold services are generally provided on a drop-in or outreach basis, and do not require service users to be abstinent or substance free (Strike *et al*., 2013). Interventions typically focus on ensuring that basic needs are being met (housing, food and medical) and where a collaborative style is used to implement harm reduction strategies (Fernandez *et al*., 2006).

The research literature suggests that the provision of low-threshold services, coupled with harm reduction interventions, can both address and reduce immediate risk in the lives of service users (Bates *et al*., 2017). Low-threshold approaches may be effective in breaking down barriers that prevent access to treatment (Strike *et al*., 2013) when service users feel unable to access treatment because of system, social and personal/interpersonal factors (Notley *et al*., 2012). The way that thresholds are defined may affect how practitioners engage with clients. Edland-Gryt and Skatvedt (2013) argue that beyond the three thresholds already identified in the literature (registration, effectiveness and competence), a fourth threshold was "trust", although how this can be developed is not extrapolated upon. Despite these apparent advantages, the concept of low threshold has also been subject to criticism. It can be difficult to define thresholds (Islam *et al*., 2013) and in removing barriers to access there may be concerns about the safety of staff, service users and the local communities (Eversman, 2010). Several ethical issues have also been raised associated with onsite drug dealing and taking, levels of intoxication while engaged with practitioners, and service user non-engagement with health services (Solai *et al*., 2006).

The role of the practitioner relationship

How practitioners relate to clients is crucial to the therapeutic milieu (Meier *et al*., 2005; Tompkins and Neale, 2018), as well as the personal values that drugs workers' hold (Phillips and Bourne, 2008). Wright's (2004) idea of relational distance is helpful in this respect, where she calls for relationships that allow an intimacy of understanding, compassion and transparency between practitioner and client, in order to foster both caring for others as well as self-care. It is in these drug treatment and intervention policy landscapes, including the challenges in delivering low-threshold service provision, that the current study is located. The aim of the study was to explore the development and challenges of providing community-based low-threshold drug intervention services within a socially excluded urban area in Dublin, and this paper considers the tensions, challenges and skills practitioners use within such connects in order to connect with, and provide services to, those most marginalised, excluded or hard to reach substance use populations.

Method

The research for the study was undertaken by university–community research alliance using a community-based participatory research (CBPR) approach (Blumenthal, 2011). This approach seeks to utilise methodologies that address traditional power dynamics, as well as bridging the gap between research and action (Gray *et al*., 2015). A key aspect of the method was the involvement of co-operative inquiry groups (Reason and Bradbury, 2007). These are viewed to not only enable the researcher to query, investigate, consider practice and social phenomena, but to achieve individual and social change (McArdle, 2002). There is a recognition however that, in seeking to explore such complex topics and to co-create knowledge, and act on this knowledge, it is inevitable there is a messiness and fragility to the method (Senge and Scharmer, 2008). However, it is argued that co-operative inquiry, with its cycles of action and reflection, can better generate contextually embedded knowledge that emerges from experience (Brannick and Coghlan, 2007).

The setting

The study took place in an urban housing development that lacked historically structural, economic and cultural resources. Despite significant urban regeneration in such communities in Ireland, life is characterised by the high levels of poverty and problematic substance use with limited economic and employment opportunities (O'Gorman *et al*., 2016). The drug intervention agency where the research took place offers a range of interventions including counselling, a day programme, a community-based detox service, infant health support, education and training and drop-in services. The aim of the low-threshold service is to engage with and support active substance users who experience difficulty attending structured, one-to-one appointments and to later progress clients into different parts of the organisation (counselling, keyWorking, education and training) as their substance use stabilises or they engage consistently with the low-threshold services. Responses include harm reduction interventions, responding to basic needs through the provision of food, shower and washing facilities and ensuring that primary health and other medical needs are addressed through referrals and advocacy. Harm reduction is relationally based and focusses on brief and sustained interventions which include safer use, minimising harms of poly use and responding to social and community harms of drug related debt and criminality. The visibility of those progressing from low-threshold services to more structured services often creates a tension between the different cohorts of service users. Like in other settings, providing such services the agency has faced issues of risk to staff and service users. This includes generalised concerns about health and safety where service users are intoxicated, using substances on the premises, overdosing and becoming aggressive or violent. The client group is often experiencing multiple and complex issues, including active poly substance use and associated risky behaviours; physical and mental health issues; involvement in criminality; homelessness; debt and disruption to parenting and family functioning. Service users often experience exclusion from other services and settings as a result of these multiple social and psychological problems and are both referred and may self-refer.

Participants

All the practitioners ($n = 9$) involved in the study were employed by the agency including five men and four women ranging from 36 to 56 years. All research participants had extensive experience, accreditation and professional recognition in carrying out drugs intervention work, using skills in motivational interviewing, cognitive behavioural, client centred and solution focussed brief therapeutic approaches in delivering low-threshold interventions.

Procedure

Ethical approval was gained from the first author's university's research ethics committee. Participants provided written consent and were informed that they could leave the study at any time. In terms of duty of care, existing support and supervision structures were offered in the event of possible distress experienced by participants. It was agreed that no identifying client details would be disclosed. The data were collected during the process of four cycles of co-operative inquiry group sessions. Paying fidelity to the CBPR approach, participants were involved in the structure and design of the four co-operative inquiry group sessions, which were run over a three-month period. The groups were facilitated jointly by an academic from the university and a practitioner researcher from the community agency. Prior to the inquiry group process commencing, ground rules were agreed by all participants to include: manner and types of interaction, managing disagreements, discussion of client details and attendance and participation in the co-operative inquiry process. The inquiry groups sought to engage in cycles of action (practice) and reflection and the focus of discussions for each group emerged both from practice and from theory (Reason and Bradbury, 2007). Initial points of inquiry focussed on the current issues that were emerging for the agency in relation to how low-threshold services were being delivered. The authors facilitated the discussion, guided debates and were involved in deepening or questioning of aspects of issues being deliberated upon (McArdle, 2002). Notes were taken of each inquiry group and the focus for the following one agreed at the end of each session, whilst also allowing for new issues, themes or discussion points to be introduced by the practitioners.

The four inquiry groups ran for 90 min, were audio recorded (with permission from the research participants) and later transcribed and resultant data analysed thematically (Hardwick and Worsley, 2011). To refine the data and make it more manageable (Miles and Huberman, 1994) two levels of coding, open and axial (Strauss and Corbin, 1998), were conducted. The first step allowed for categories to be identified and assigned to elements of the recorded material and the second step allowed for relationships between the categories to be established (Strauss and Corbin, 1998). Importantly group members participated in the discussion and formulation of the themes in light of the aims of the research, together with the thematic analysis. To protect the identity of the research participants' they have been anonymised.

Findings

Within the context of the unique difficulties of building relationships with clients who may be pre-harm reduction and the safety issues or engaging with those who are actively using substances, three key themes in relation to client–practitioner relationships and client outcomes emerged from the analysis of the data: the mechanisms by which the practitioners engaged with their clients and sought to develop relationships; how safe spaces were created and maintained in order to address client needs; practitioners' understanding of challenges and outcomes in low-threshold intervention work.

Practitioner views on client engagement and relationship building

For most participants relationship building was viewed to be central in using the low threshold approach, as one practitioner put it:

> The key aim is to "come as you are" and trying to get the person to come back to us again. The more the relationship develops, the more we can see the range of responses that is possible for that person

> and I think the challenge is to continue to stay with "come as you are" […] as well as needing to be mindful that what I do doesn't lose the trust that has been built within the relationship with the client. (Practitioner 3)

Given the nature of hard to reach or highly excluded populations, it was crucial that a positive early engagement was achieved to allow for future therapeutic outcomes. In addition, time spent with clients was identified as key even where the pace of change was slow, it was important to continue to offer a containing, therapeutic relationship:

> Even though we might think that we are not doing much I think that humanistic model of just spending time with someone is important, they might not have ever got that from other services. It might build up to them being able to trust us or maybe to go on to another service. Even though it might not seem like a lot it can lead on and may be a profound change for someone. (Practitioner 1)

The process of establishing professional boundaries was described as challenging at times and particularly given the sometimes unconventional nature of the work, as the following excerpt describes:

> There was a call made from a concerned family member about this person. He was in treatment he didn't or couldn't manage so they kicked him out. We drove 40 miles or something like that to go and collect him. He hadn't been drinking in a few days, we were thinking trigger, so let's clear the flat of all the drink that was in there. So that's a line that we felt that we needed to take, we felt that was the right response at that time for the client. (Practitioner 3)

Having to negotiate ambiguous personal and professional boundaries was identified as an ongoing challenge, particularly the boundary between practitioner and friend, given the time spent with individual clients in often informal settings:

> I was a bit shocked when this person described me as his friend, it was "you and me mate". I said we do have a relationship, it's a professional relationship. Again, it's the point I was trying to get across to them without killing the relationship. I don't think I really did. He just didn't get it. I think there is an inevitability when you are working with somebody for two years how they are going to see it, you know. (Practitioner 6)

A number of strategies was used to deal with such boundary issues, for example, by clearly outlining to the client what the purpose and limits were of their work together was and explaining why certain actions or activities were not appropriate. The complexities of this negotiation were made more difficult because clients were less likely to have experienced generative client–practitioner relationships previously and so may be less aware of the norms and boundaries of such relationships.

Safe spaces and meeting needs

How safety and risk were addressed within these relationships was key for the practitioners. In particular, attention was being paid to the issues related to intoxication, violence and drug dealing. One practitioner described how they needed to stay both vigilant yet relationship focussed:

> We try to bring a 360° view to the drop-in. There are different spaces we need to operate in so if people come in for a game of pool in the pool room, some are inside for a discussion but you could have 10-20 people in the drop-in in that hour so there is something about the qualities needed in a team to ensure that the service is delivered professionally and properly in that way and constantly making risk assessments. (Practitioner 3)

The practitioners described the importance of clarity of staff and client roles and responsibilities to reduce risk and create safety as highlighted in the dilemmas faced by this practitioner:

> Being able to have the genuine conversation with people about their destructive behaviour and then being able to offer a one-to-one service as the drop-in service is not working for you due to the dynamics of your behaviours. It was a struggle to say to people this is not about exclusion but inclusion in a different way. (Practitioner 4)

The nature of the low threshold approach inevitably created unusually risky circumstances and encounters that required a responsive and holistic skill set:

> You have to be skilled at making that assessment around what is the intervention required here, what is the best response. You have to be screening for all the issues- is it a drug issue, is it a mental health issue, is it a homeless issue, is it primary health care issue. (Practitioner 3)

Challenges and outcomes in low-threshold services

One of the issues identified in the literature is the rather ill-defined nature of low threshold approaches involving many variables that are complex and difficult to control for. Thus, the conventional outcome measure in addictions policy and practice, abstinence, was an unlikely goal for clients in this field. They were working with a cohort of service users who were not actively seeking change in terms of their substance use who were more likely engage with more needs based issues and crises such as financial debt, a looming prison sentence or health need:

> I think they come in here on a needs basis because they go to the clinic for their methadone and there are other places they can go, but in here it is a needs basis and their needs aren't about change. There is crisis, there is a debt, it is always an immediate need, whereas with other clients there is a growth happening. (Practitioner 2)

A focus on harm minimisation in situations of complex drug use and social needs, especially when clients missed appointments, was commonplace. As a result, there was a need for practitioners to adopt looser, more informal contact arrangements:

> In a drug free group, we expect them to be drug free, and consistent in their attendance. If they can't make an appointment, they will ring up and apologise so that the appointment can be offered to someone else. With low threshold […] when they come in they might be intoxicated, and we are OK with that. Depending on the threshold our expectations change. (Practitioner 5)

Providing a space for social contact or meeting basic needs at least for that hour of contact was viewed to be a positive achievement:

> I did some harm reduction and some affirmation work and the hour he was with me he wasn't using drugs. He just wanted to have a game of pool. If I think about "have I done anything progressive with this client today", I would probably say no but he would say well I wasn't using drugs, so something is happening. (Practitioner 8)

A perception that such outcomes were not often recognised by funders of the service was commonplace in respondents' views:

> When we sit down and talk about what we have done we can name those things, but in terms of funders and outcomes and value for money that is where it becomes more of a struggle. (Practitioner 5)

Discussion

The study findings help elucidate aspects of the practitioner experience in this form of community-based drug service, outlining a range of expectations and strategies used to engage with service users that are often pre-harm reduction. In finding ways to better understand the complexities of clients' issues and their active substance use, a "come as you are" ethos (Marlatt, 1996) characterised practice. These minimal expectations appeared to facilitate and promote client engagement and deal with some of the shame and stigma that service users often experience. Recognising hope but without expectation and promoting respect in this client group is complex and challenging value positions that practitioners appeared to be embracing. On the other hand, finding ways of making boundaries clear, yet at times necessarily permeable, was a reminder of the nature of the low threshold approach. Such boundaries are more likely to shift and change, become more blurred, than is the normative in drug and alcohol services (Fournier *et al*., 1993). This phenomenon can partly be explained by the unusual contexts of practice where contacts are often made "off-site", for example in home and hospital visits, street outreach and advocating on the client's behalf with other agencies. How these boundaries are managed and negotiated by practitioners may be a key in sustaining client relationship and practitioner well-being. A parallel can be found in Wright's (2004) model of "relational distance" that communicates both the care for the person being worked with and the boundaries of this care and support, in the criminal justice system. It is argued that careful attention to the "relational mid-point" for practitioners can ensure that the client experiences being cared about, as well maintaining practitioner motivation and self-care. Clients do not present in a uniform ways, particularly with a client group whose lives are often chaotic and dislocated from conventional social norms (Fournier *et al*., 1993). The relational mid-point can enable practitioners to respond to uncertainty and change in these circumstances.

The building of client trust has been identified as a vital element in delivering a low-threshold service (Edland-Gryt and Skatvedt, 2013). In this study, positive client and practitioner interactions appeared to engender such trust, particularly for those at end of life or having serious ongoing health issues related to their substance use (McNeil and Guirguis-Younger, 2012). The values of the practitioners appeared to underpin trust building, but, there were differences in how practitioners contextualised these values in their interventions and in their interpretation of operational policies. This may have the potential to cause tension between practitioners or between practitioners and the organisation, an issue that has been raised in the literature (Fournier *et al*., 1993; Strike *et al*., 2013).

Service providers have reported encountering many challenges in engaging with and responding to the needs of clients within low-threshold services (Eversman, 2010), as did the practitioners in this study. Of particular note were concerns about managing risk to staff and other service users, for example, onsite dealing or violence that compromised or posed a risk to staff or other service users. It can be argued that an alternative value set was required by practitioners when working with client behaviours that are so often viewed to be "morally and legally wrong in contemporary neo-liberal society" (Karasaki *et al*., 2013, p. 203).

This notion of an alternative, or compromised, value base, can be understood to be part of the practitioner's experience in an area of service delivery that is less likely to be working with stabilised and abstinent service users. It would appear that working with clients who are intoxicated creates different forms of emotional content associated, for example, with disclosures about drug taking, drug dealing or harm to self. The location of practice, often off-site, raises an unusual set of potential risks which often requires practitioners to literally transverse the landscapes of their client's lives. Where organisational policies and procedures can be a touchpoint for ethical and effective practice (Kleinig, 2004), in many of the situations being described, a strong organisational policy response may come at the cost of the loss of the client–practitioner relationship, reinforce barriers to access for clients and ultimately affect levels of engagement and outcomes (Strike *et al*., 2013). Practitioners may need to both nurture interpersonal relationships whilst paying attention to community relations and social controls on behaviour.

A related issue discussed by practitioners was the relatively lowly regarded nature of the service which does not attract sufficient funds; as a result, there was frustration about missed opportunities to effect change for their clients. Yet the practitioners appeared to value what was perceived as positive changes in clients' lives and where non-progression occurred, there was still a commitment to support and the use of limited resources (Lee and Zerai, 2010). Broader questions remain about both the outcome driven focus of neo-liberal funding models that by their very nature fail to take account of the community and social context for individuals (Fursova, 2016), and more subtle positive changes for those experiencing complex or longstanding issues (Timpson *et al*., 2016). An argument has been made that there should be recognition of "modest positive changes" such as improved psychosocial functioning and increased well-being and stability for those presenting to services with complex needs (Tompkins and Neale, 2018, p. 53). In the absence of funders' understandings of the attention and skills required to maintain low-threshold services, it is difficult to see how such subtle approaches that are hard to evidence base, might be recognised by governments and policy makers (Moore and Fraser, 2013), although emerging tools such as those developed by Neale *et al*. (2016) provide some possibility of capturing outcomes that better reflect the quality of life outcomes within substance use intervention.

The way that practitioners spoke about the possibility of hope and progression for their clients, informed notions of what might constitute good practice in this area (Melles *et al*., 2007). As Duff (2015) argues, if we were to promote health rather than to simply seek to either prevent use or reduce harm, then we may be better positioned to both address the social and economic disadvantages that are experienced by some of those using substances, and understand that such use is functional in helping people negotiate life. Ireland's recently published drug strategy (Department of Health, 2017) aims to promote recovery and reduce harm, so while the introduction of an explicit harm reduction focus has been welcomed in many quarters, there are few explicit actions in relation to either cultivating self-care and actively addressing the social and economic disadvantages significant proportions of those who use substances face (Citywide, 2017). The challenge then for service providers and practitioners may be how to prioritise relationship and promote both care and self-care in low-threshold services (Lee and Zerai, 2010).

Conclusion

It has been argued in this paper that drug and alcohol interventions that narrowing service users' needs to single presenting issues of problem substance use and resulting discrete episode of care response (Moore and Fraser, 2013) does not necessarily serve the needs of those using substances or experiencing complex issues. Low-threshold drug services may inadvertently sustain such a treatment landscape by limiting the visual reminders of poverty, social exclusion and problematic substance use from streets and public spaces, particularly within urban settings (Langegger and Koester, 2016). While low-threshold services may be viewed as a small niche response within the wider field of treatment and service provision, this study indicates that practitioner skills and values in delivering low-threshold interventions may provide key principles that can inform a stronger relational and health based approaches to substance use intervention (Neale *et al*., 2016). In purposefully working to understand, and respond to, the complex social and economic contexts of peoples' lives, and incorporate an understanding of the functionality of substance use (Duff, 2015), there is the potential to address some of the critical questions at the heart of substance use policy and intervention (Fraser, 2017). The imperative for practitioners in seeking to challenge existing norms of episodic treatment may be to capture Wright's (2004) idea of relational distance, where she appeals for an intimacy of understanding, compassion and transparency between the practitioner and client, in order to foster both caring for others and self-care. Relationally focussed low-threshold services can then potentially align with Duff's (2015) call for drug policy and responses based on "a concern for the welfare of drug consumers, without demanding that they adhere to universal norms of behaviour" (p. 94).

Study limitations

This was a qualitative action research study that sought to engage a group of practitioners in one setting to discuss, debate and consider the low-threshold intervention work and practices within their community-based organisation. A limitation of the study is that it did not ascertain the views of clients. Further exploration of the pivotal role of building and sustaining practitioner and client relationships and the development of client trust in delivering low-threshold service provision within a range of low-threshold services would be valuable, particularly if client views and experiences were also included. In addition, further research is required on managing risk and the challenging issues clients may present with, as well as the impact of these dynamics on practitioners within both urban community-based and city-centre low-threshold services.

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Social representations of polydrug use in a Finnish newspaper 1990–2016

Jenni Savonen, Pekka Hakkarainen, Kati Kataja, Inari Sakki and Christoffer Tigerstedt

Abstract

Purpose – *The purpose of this paper is to study the social representations of polydrug use in the Finnish mainstream media. Social representations are shared ways of talking about socially relevant issues and have ramifications on both individual and socio-political levels.*

Design/methodology/approach – *The social representations theory and the "What's the problem represented to be?" analysis provided the theoretical framework. In total, 405 newspaper articles were used as data and analysed by content analysis and thematic analysis. The key tenets of the social representations theory, anchoring, objectifying and naturalisation, were used in data analysis.*

Findings – *The study found that polydrug use was written about differently in articles over the study period from 1990 to 2016. Three social representations were introduced: first, polydrug use as a concept was used to refer to the co-use of alcohol and medical drugs. This was seen as a problem for young people, which could easily lead to illicit drug use. Second, illicit drugs were included in the definitions of polydrug use, which made the social representation more serious than before. The typical polydrug user was portrayed as a person who was addicted to substances, could not quite control his/her use and was a threat to others in society. Third, the concepts were naturalised as parts of common language and even used as prototypes and metaphors.*

Originality/value – *The study provides a look at how the phenomenon of polydrug use is conceptualised in everyday language as previous research has concentrated on its scientific definitions. It also adds to the research of media representations of different substances.*

Keywords *Finland, Drugs, Social representations, Print media, Polydrug use, WPR-analysis*

Paper type *Research paper*

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Introduction

Adding to studies on alcohol and other substances, research regarding multiple substance use has increased over the past decades. Polydrug use is argued to be the dominant pattern of substance use in Europe (EMCDDA, 2011) and it has also become an issue of debate in scientific research. Polydrug use has been conceptualised in different ways, often defined as either simultaneous or concurrent use of two or more substances. The strictest definitions consider only illicit drugs, while most include alcohol and some include tobacco (e.g. Martin, 2008; Schensul *et al.*, 2005). This paper extends the discussion by contributing to the understanding of the concept of polydrug use from a common language perspective. Setting aside the definitions given to polydrug use by researchers, other professionals or even substance users themselves, how is polydrug use conceptualised in mainstream, everyday language?

The paper studies everyday language about polydrug use in Finland. In a country with more liberal attitudes towards drinking and drunkenness (Härkönen, 2013), the use of illicit drugs is regarded as moralised and stigmatised behaviour. In Finland, the term "narcophobia" has been used to describe the fearful attitudes of people towards the experimenting with and use of illicit drugs (Partanen, 2002). Polydrug use, specifically, is both nationally and internationally often seen as a very problematic form of substance use (Meacham *et al.*, 2015; Medina and Shear, 2007; Perälä *et al.*, 2012). Despite recent findings on the diversity of polydrug use (e.g. Kataja *et al.*, 2017), it has been treated as a rather homogenous subculture and polydrug users as a relatively uniform group of substance users (Perälä *et al.*, 2012).

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The everyday language about polydrug use will be studied by focusing on its social representations. Social representations are culturally shared ways of talking about socially meaningful issues and shape the way these issues are perceived. In the case of polydrug use, its social representations have considerable ramifications at both individual and socio-political levels. The way we talk about multiple substance use affects the identities of the people involved and can further social exclusion and discriminatory policies. Social representations are strongly constructed and maintained by the media. For this reason, the paper looks at how the concepts of polydrug use and polydrug user are applied in Finland's largest newspaper. In order to capture the evolution of these social representations, articles from the year 1990 until the year 2016 will be studied.

Social representations

The social representations theory originates from Serge Moscovici's (1961) study on how the theory of psychoanalysis spread from the scientific community into the everyday conversation of French people. The role of the media was central as information was distributed through the liberal, catholic and communist press. Each medium reported on psychoanalysis from their particular points of view. According to Moscovici (1961), the liberal press favoured diffusion, which was a seemingly neutral way of disseminating information. The more conservative catholic press passed information through propagation: emphasised the content contingent with religious beliefs and defied other parts of psychoanalysis. The communist press used a propagandist approach by attacking against psychoanalysis, which was seen as highly bourgeois. The different ways of reporting resulted in readers having very different views on psychoanalysis. These views were named social representations.

Social representations are defined as groups of values, ideas, images and practices. Their two main purposes are first, to help people orient in their social and material worlds and second, to allow communication with others (Moscovici, 1973). Social representations are more than attitudes towards a certain issue or subject; they are lay theories or systems of beliefs (Moscovici, 1984).

According to the social representations theory, new and abstract information is adopted into everyday language through the processes of anchoring, objectification and naturalisation. Through anchoring, strange phenomena are compared to ordinary categories and placed in familiar contexts; abstract issues are named and classified. Objectification refers to finding the iconic nature of a strange concept and producing it as an image (Moscovici, 1984). Through naturalisation, the once new and abstract ideas are rooted as a part of our social and cultural reality: they become a part of common or everyday language (Sakki and Menard, 2014).

Recent texts on social representations have theorised their functional aspects and emphasised their connections to identities, interpersonal relationships and power. The close connection of social representations to political sciences, societal conflicts and institutions has been increasingly addressed (see Elcheroth *et al.*, 2011). To focus on these functional aspects of social representations, this paper combines the social representations theory to a poststructural policy analysis "What's the problem represented to be?" (WPR) (Bacchi, 2009; Bacchi and Goodwin, 2016). WPR-analysis is used to study problem representations in society, which are presumed to be reflected in social policies.

Although not policy analysis, this paper benefits from the emphasis of studying problem representations rather than pre-assumed problems, and specifically, the consequences of these representations. They carry implications for how a specific issue is thought about and how the people involved are treated (Bacchi, 2009). Problem representations are assumed to benefit the members of some groups at the expense of others and limit our awareness of the full range of troubling conditions (Bacchi, 2009).

Because problem representations are reflected in practices, the premises of policy actions and their underlying representations need critical interrogation. The aim of WPR-analysis is to challenge problem representations that have deleterious effects, and to suggest that issues can be thought about in ways that might avoid these effects (Bacchi, 2009). In combination,

the social representations theory and the WPR-analysis offer a conceptual framework to explore the meanings and, particularly, the individual and societal ramifications of the representations of polydrug use.

Social representations of substances in the media

Communication is a key factor in the creation of knowledge (Elcheroth *et al.*, 2011), which makes the role of the media significant in defining questions related to substance use (e.g. Montonen, 1996; Coomber *et al.*, 2000; Lancaster *et al.*, 2011). Representations of alcohol in the print media vary from focusing on alcohol-related harms such as alcoholism or drunk-driving to portraying alcohol use as a neutral or even positive social activity (e.g. Törrönen and Simonen, 2015). Reporting on illicit drugs, however, is often stereotypical and distorted, focusing more unilaterally on criminal behaviours associated with drug use (Coomber *et al.*, 2000; Ayres and Jewkes, 2012; Taylor, 2008). Accordingly, a study of Finnish print media showed that illicit drugs were portrayed as a problem or threat, moral panic being a distinctive feature of drug-related newspaper articles (Törrönen, 2004). However, it has also been suggested that media reporting on illicit drugs is not as sensationalised and biased as traditionally proposed, and that there are notable differences between the reporting of different illicit substances (Hughes *et al.*, 2011).

Studies of different substances and addictions under the social representations framework have also shown social representations of alcohol to include ambiguous messages on the social acceptability of alcohol use on one hand, and its potentially harmful effects on the other (Hirschovits-Gerz, 2014). A study comparing social representations of different addictive behaviours internationally found alcohol use to be regarded as less of a problem in Finland than in Sweden, Russia and Canada (Holma *et al.*, 2011). “Hard” drug use is seen as the most severe form of addiction and a cause of societal problems in most countries (Blomqvist, 2009; Holma *et al.*, 2011; Hirschovits-Gerz, 2014).

The misuse of medical drugs has not been studied as much as that of alcohol and illicit drugs. The social representations of prescription medication have traditionally been positive due to their health promoting effects (Hirschovits-Gerz, 2014). This view is currently challenged, for example, due to the opioid crisis in the USA, which has been declared a “national emergency” (Global Commission on Drug Policy, 2017a). The misuse of medical drugs is also an increasing concern in Europe (Karjalainen *et al.*, 2017).

Although we have evidence on the social representations of alcohol, illicit drugs and medical drugs, the social representations of polydrug use remain an unexplored area. This paper aims to contribute to this question by asking: which substances are included in the definitions of polydrug use in newspaper articles? What kinds of social representations are the articles creating and maintaining? How have the social representations changed from the year 1990 to the year 2016?

Data and methods

The data for the study consist of 405 articles from the Finnish daily newspaper *Helsingin Sanomat*. *Helsingin Sanomat* is the biggest circulation newspaper in all of the Nordic countries, with a total daily distribution of 324,997 in 2017 (Media Audit Finland, 2017). It is an important setter of public debate and standards for other media in Finland (Lounasmeri and Ylä-Anttila, 2014). The electronic archive includes all articles published in the newspaper from the year 1990 onwards. The year 1990 was chosen as a starting point for the present study due to the timing of the second wave of increased drug use in Finland in the 1990s. During that decade, the significant increase in drug use also resulted in increased reporting on drug and substance misuse issues (e.g. Törrönen, 2004).

A search was conducted in the archive to find all articles mentioning polydrug use or polydrug user during the study period. In Finnish, polydrug use has few synonyms, and the most common concepts *sekakäyttö* (polydrug use) and *sekakäyttäjä* (polydrug user) in all their inflected forms were used. The subject of the articles was not significant for this study, because the aim was to look at all the different contexts and ways the concepts had been used in newspaper articles over the years.

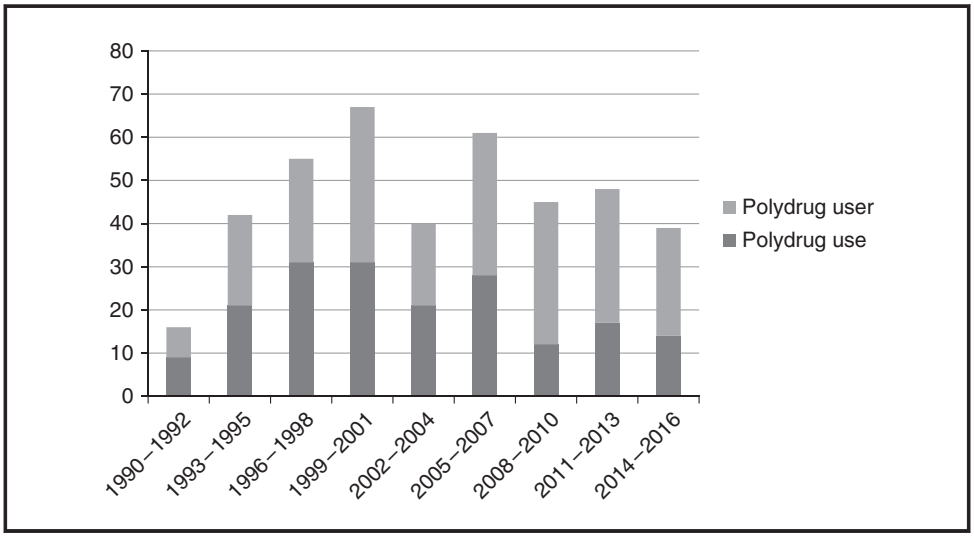
This paper applies both content analysis and thematic analysis to analyse data. Quantitative aspects of the data will be demonstrated through content analysis: how often and in what kinds of contexts the concepts of polydrug use or polydrug user were used in newspaper articles. Thematic analysis (Braun and Clarke, 2006) provides a qualitative method that allows identifying, analysing and reporting patterns in data. Braun and Clarke (2006) introduced six interconnected phases of the analysis, which have been applied in this study. First, the researchers read the articles thoroughly to familiarise themselves with the data. Second, an inductive approach was used to form initial codes on the data. These were coded with Atlas.ti. The subsequent three phases concerned searching for, reviewing and defining recurrent themes in the data. Themes are defined as patterned responses that capture something important in the data in relation to the research question. During these phases, the themes were compared to see if they reoccurred during the entire study period from 1990 to 2016 or only at certain points in time. Co-occurring themes were grouped together and will be introduced as the social representations of polydrug use.

Results

The concepts of polydrug use and polydrug user were not very commonly used in newspaper articles at the beginning of the study period in 1990–1992 (Figure 1). However, their use quickly increased and continued to do so until the turn of the century. After this, the use of the term polydrug use has somewhat decreased, but polydrug user seems to have appeared in the articles more steadily.

A longitudinal exploration of the data showed that the social representation of polydrug use had changed in the study period from 1990 to 2016. The social representations seemed to differ mainly according to the substances that were included in the definitions of polydrug use at specific times. At the beginning of the study period, polydrug use most often referred to the co-use of alcohol and medical drugs. Later, illicit drugs were included in the definitions. Next, the evolution of the concept will be described by introducing three social representations that were identified in the data. All citations are from newspaper articles published in *Helsingin Sanomat*. The key processes of the social representations theory; anchoring, objectification and naturalisation will be used in the analysis.

Figure 1 Mentions of polydrug use and polydrug user



The polydrug use of alcohol and medical drugs

Figure 2 roughly shows the substances that were included in the definitions of polydrug use and polydrug user throughout the study period. In the beginning, writers clearly spelled out the substances they were referring to when using these still unfamiliar concepts. Polydrug use at this time most often referred to the co-use of alcohol and medical drugs:

> After working with substance users for almost 20 years, I've noticed that there are less "pure" alcohol abusers; they've been substituted by polydrug users of alcohol and medical drugs (1992).

Polydrug use as referring to the co-use of alcohol and medical drugs was strongly anchored to alcohol use. In other words, the new and abstract idea of polydrug use was contrasted to alcohol abuse, which was a well-acknowledged and familiar issue. Polydrug use was also discussed as a form of substance use distinct from illicit drug use:

> During this time, substances used by clients have moved from alcohol to drugs; it is rare to have a pure alcoholic at the facility. The usual distribution of clients is a couple of drug addicts, a couple of polydrug users and one alcoholic (1998).

> […] [N]ot forgetting the dangers of alcohol use, polydrug use and even heavier drug alternatives, the boy interviewed for the program thought drinking beer was just a phase in life which would pass, just like pimples (1997).

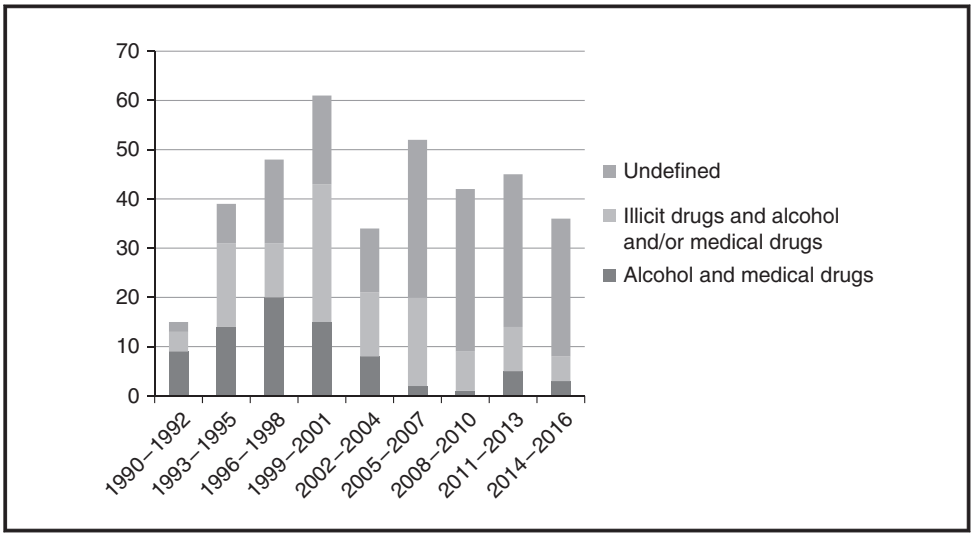
In the previous citations, substance use problems were organised into a sort of continuum, where alcohol use was positioned at the most harmless level, followed by polydrug use (as referring to the co-use of alcohol and medical drugs) and finally illicit drug use as the most severe form of substance use. Polydrug use was often explicitly described as a pathway from alcohol use to illicit drug use:

> Finnish people's favorite substance is still booze, but the polydrug use of alcohol with medical drugs is now almost as common. It is also easier to slip into illicit drugs from alcohol and medical drugs (1997).

> Especially young people mix beer, wine, spirits, sleeping pills and pain killers, sedatives and cough medicine. The phenomenon is concerning because this polydrug use easily leads to illicit drug use (1996).

At the beginning of the study period, polydrug use was seen as a typical form of substance use, especially among teenagers: where they had previously become intoxicated by drinking beer, they would now mix in medical drugs as well. In the first social representation, polydrug use was therefore objectified as a young person experimenting with medical drugs alongside alcohol use. The articles often portrayed concern for this emerging trend.

Figure 2 Substances included in polydrug use



The polydrug use of illicit drugs, alcohol and medical drugs

During the 1990s, the concepts of polydrug use and polydrug user started to gain new meanings. Many writings still used the concepts to refer to the co-use of alcohol and medical drugs, but by the turn of the century, illicit drugs were predominantly included in the definitions:

> Old school drunkards don't exist anymore. They've been replaced by people who substitute alcohol with windshield washing fluids and polydrug users. Polydrug users use medical drugs and illicit drugs in addition to alcohol (2000).

Now, the concept of polydrug use was often used to refer to the co-use of alcohol, medical drugs and illicit drugs. The addition of illicit drugs in the social representation made polydrug use a more serious form of substance use than before. When it had previously been considered as substance use that could lead from alcohol use to illicit drug use, it now connoted illicit drug use *per se*. Polydrug use was positioned as being something even more harmful than illicit drug use:

> People seeking help for drug abuse problems are mostly men, young adults and people living alone. The treatment periods have become longer, because the clients are more often polydrug users and in poorer shape than before (2007).

> The use of IV drugs has spread in such a short time, that Finland's treatment systems have not been able to keep up. In addition, the unexceptionally profuse polydrug use of different illicit drugs, meds and booze makes treatment more difficult than in other countries (2001).

Polydrug use was often anchored to emotions (emotional anchoring, see e.g. Höijer, 2010), which portrayed it as a threat or danger. These articles implied that polydrug use was something alarming and dangerous that needed to be feared. Mixing different drugs was pharmacologically dangerous, but so were the people who were referred to as polydrug users. They formed a group whose behaviour was often described as unpredictable:

> The traditional alcoholic bum has disappeared from Helsinki. Customers are younger and more international than before. The polydrug use of illicit drugs or of booze and illicit drugs is common, which makes people unpredictable (2004).

In this social representation, polydrug use was objectified in a different way than before. When previously the typical polydrug user had been a young person experimenting with substances, she/he was now portrayed as an older person and someone who was very likely addicted to substances. Polydrug users were presented as people who could not quite control their own behaviour and caused insecurity in public spaces.

Naturalised polydrug use

The final social representation shows polydrug use and polydrug user as naturalised concepts. The terms seemed to have become a part of everyday language and were no longer issues of debate in the same way as before. Naturalisation can be seen in the way the concepts were defined over the study period. At first, polydrug use was used to refer to the co-use of alcohol and medical drugs, while later illicit drugs were included in the definition. Towards the end of the study period, the concepts of polydrug use and polydrug user were already familiar to the public and were often used as individual concepts as such, without defining or specifying which substances in particular were being co-used (Figure 2).

Although newspaper articles often left out the substances they were referring to by polydrug use towards the end of the study period, the inclusion of illicit drugs in the combination seemed to be implicitly implied:

> The majority of homeless substance users in Helsinki are still middle-aged men addicted to alcohol […] (H)owever, the amount of homeless young drug addicts and polydrug users is increasing (2006).

The Finnish term for polydrug does not have a straight reference to drugs, as it translates into mix-use, but the naturalisation of the concept has led to a strong implication of substance use (especially illicit drug use) when it is being used.

In this third social representation, the concepts of polydrug use and polydrug user were found to separate from each other more than before. Polydrug user was mentioned more often in articles by the end of the twenty-first century. This trend coincides with the finding that the concepts

were used independently of specific definitions, allowing more room for the reader's own interpretation. Interpretations will likely include elements from existing social representations and frame the concept of polydrug user in an especially negative way.

The concept of polydrug user was used in pejorative contexts, also in articles unrelated to substance use. The concept was not necessarily used to refer to people who were mixing certain substances, but as a categorisation of a person with certain assumed characteristics. Polydrug user was used as a prototype of a person who was addicted to substances and had low control of his/her use and potentially caused disturbances in public areas:

> A restless threesome get on the bus, two men and a woman. They take over the best seats in the front. They are quickly given room, because they have low voices, rundown faces and a shabby appearance acquired by a long history of substance use. The diagnosis is clear: druggies and unpredictable polydrug users; the kind you need to be very careful with (2014).

Polydrug use and polydrug users were even used as metaphors:

> Playing with your phone can't be a big sin if you consider children's toys nowadays. For example, our child has a plastic caterpillar, which speaks in a monotonous voice and repeats like a polydrug user "The dog and cat take the airplane to see the flower". It sure doesn't improve European small talk (2013).

> Talking vegetables end up time traveling as pirates. The cheap and disturbing animation feels like something invented in a polydrug use-hangover (2014).

These citations show that the concepts of polydrug use or polydrug user had naturalised and become so familiar, that they could be used figuratively in various contexts. When applied in this stereotypical way, the negative social representations are particularly strongly maintained.

Discussion

This paper has studied the social representations of polydrug use and polydrug users in Finland from 1990 to 2016. Three distinct representations were introduced. At the beginning of the study period in the 1990s, polydrug use often referred to the co-use of alcohol and medical drugs. This was viewed as typical behaviour for young people. Closing to the turn of the millennium, the social representation of polydrug use entailed illicit drugs, which shifted the phenomenon in a more serious direction. The third social representation portrayed polydrug use as a naturalised concept, and it was often used as a prototype or a metaphor.

Social representations are an important object of study, because they are not just ways of talking about issues. They actually work to constitute or construct our social reality, which has significant implications for society and individuals (Elcheroth *et al.*, 2011; Bacchi, 2009; Taylor, 2008). Social reality is constructed through representations because "we react to the representation rather than the reality they represent" (Farr, 1995). According to the WPR-analysis, representations have discursive, subjectification and lived effects (Bacchi, 2009).

First, discursive effects have consequences on how we talk about issues and what we believe to be "true". For example, a study of how methamphetamine use was constructed in the South African print media found use to be associated with criminality, pathology and discourses of, e.g., race and HIV, which portrayed people who use methamphetamine as criminals, eliciting moral stigmatisation and oversimplifying a complex socio-cultural phenomenon (Howell, 2015). In a recent report, the Global Commission on Drug Policy (2017b) recommended that policy makers and opinion leaders such as the media should be more considerate of the way of talking and reporting on drug use and drug users. They advise against using stigmatising terms such as "junkie", "druggie" or "drug abuser" and recommend using the term "person with drug dependency". In the context of this study, the same recommendation can be applied to the stigmatising concept of "polydrug user". A change in language may generate a change in attitudes and reduce the negative effects of social representations.

Second, representations have subjectification effects, because people adopt positions that are made available in discourses. Representations produce different kinds of subjects: in the present study, polydrug users are seen as a "marked" minority group whereas alcohol abusers could be

seen as the "unmarked" majority group. People who abused alcohol were positioned as a familiar and unthreatening group of people while polydrug users were seen as dangerous and unpredictable. The meanings given to certain labels and positions can have effects on the identities of people involved, because people make sense of their worlds from their respective standpoints. Anchoring or naming someone in a certain way is not just stating facts but labelling that person (Moscovici, 1984).

Third, lived effects refer to the material consequences of problem representations in people's day-to-day lives (Bacchi, 2009). Representations are often supported by the creation of institutionalised backgrounds for routine practices. They can generate infrastructure that segments people in particular ways and result in the uneven distribution of resources. Again, changes in social representations may lead to changes in the institutional world (Elcheroth *et al.*, 2011).

This study limits its exploration to one newspaper, and the social representations of polydrug use might have been different if studied in tabloid newspapers or in other media, such as online. The articles in the data have gone through an editing process and may thus reflect the ideologies and policies of the newspaper, although ideological differences between newspapers are not considered vast in Finland. It should also be noted that this paper has not aimed to explain the phenomenon of polydrug use, but has limited its exploration to the specific concepts of polydrug use and polydrug user. The critical position taken towards the application of the concept of polydrug use should be taken into account in future research and media reporting on alcohol and other substances.

Conclusions

The concept of polydrug use carries different implications in scientific research and in common language. The requirement of precise definitions in scientific articles leaves little room for interpretation based on predominant social representations. The opposite, however, applies to everyday talk and language. This study shows that polydrug use is portrayed as problematic substance use in the Finnish mainstream media. Although social representations are culture and language specific, we argue that similar negative representations could be found internationally, where polydrug use has also been viewed as problematic use (Quintero, 2009).

Recently, more studies have considered the diversity of the phenomenon (e.g. Connor *et al.*, 2013; Askew, 2016; Kataja *et al.*, 2017). According to the National Drug Survey in Finland (Karjalainen *et al.*, 2016), the most common substances used in combination were alcohol and cannabis. Such use often occurs in recreational settings among all socioeconomic groups. This co-use, however, did not show in the data of the present study. The typical polydrug user was portrayed as an addicted person rather than someone occasionally mixing alcohol and cannabis. This shows that social representations always exclude other ways of talking about an issue, making it important to consider what is being left unsaid (Bacchi, 2009). Unilaterally negative social representations can reinforce the stigma directed at people using multiple substances and people using substances in general. Promisingly, the nature of social representations as social knowledge evolves and changes over time.

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Dr Jekyll and Mr Hyde: the strange case of the two selves of clandestine drug users in Scotland

Iain McPhee, Chris Holligan, Robert McLean and Ross Deuchar

Abstract

Purpose – *The purpose of this paper is to explore the hidden social worlds of competent clandestine users of drugs controlled within the confines of the UK Misuse of Drugs Act 1971, which now includes NPS substances. The authors explore how and in what way socially competent drug users differ from others who are visible to the authorities as criminals by criminal justice bureaucracies and known to treatment agencies as defined problem drug users.*

Design/methodology/approach – *This qualitative research utilises a bricoleur ethnographic methodology considered as a critical, multi-perspectival, multi-theoretical and multi-methodological approach to inquiry.*

Findings – *This paper challenges addiction discourses and, drawing upon empirical evidence, argues the user of controlled drugs should not be homogenised. Using several key strategies of identity management, drug takers employ a range of risk awareness and risk neutralisation techniques to protect self-esteem, avoid social affronts and in maintaining untainted identities. The authors present illicit drug use as one activity amongst other social activities that (some) people, conventionally, pursue. The findings from this study suggest that punitive drug policy, which links drug use with addiction, crime and antisocial behaviour, is inconsistent with the experience of the participants.*

Research limitations/implications – *Due to the small sample size ($n = 24$) employed, the possibility that findings can be generalised is rendered difficult. However, generalisation was never an objective of the research; the experiences of this hidden population are deeply subjective and generalising findings and applying them to other populations would be an unproductive endeavour. While the research attempted to recruit an equal number of males and females to this research, gendered analysis was not a primary objective of this research. However, it is acknowledged that future research would greatly benefit from such a gendered focus.*

Practical implications – *The insights from the study may be useful in helping to inform future policy discourse on issues of drug use. In particular, the insights suggest that a more nuanced perspective should be adopted. This perspective should recognise the non-deviant identities of many drug users in the contemporary era, and challenge the use of a universally stigmatising discourse and dominance of prohibition narratives.*

Social implications – *It is envisaged that this paper will contribute to knowledge on how socially competent users of controlled drugs identify and manage the risks of moral, medical and legal censure.*

Originality/value – *The evidence in this paper indicates that drug use is an activity often associated with non-deviant, productive members of the population. However, the continuing dominance of stigmatising policy discourses often leads to drug users engaging in identity concealment within the context of a deeply capitalist Western landscape.*

Keywords *Ethnography, Qualitative research, Social identity, Drug taking, Illegal, Illicit*

Paper type *Research paper*

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Context

Dr Jekyll and Mr Hyde is a gothic novella by Scottish author Robert Louis Stevenson (1886). His choice of the name "Hyde" symbolises this character who prefers not to be recognised. Stevenson argues humans have a dual conflictual nature, and proposes the soul is an inherent

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battleground where an "angel" and a "fiend" struggle for dominance. Hyde is situated in a dark side which squeezes out Dr Jekyll. Man's essential nature lies hidden beneath the veneer of civilisation. Although "dark", illicit drug consumption is a site of "extreme enjoyment" lying outside the capitalist economy of desire and legitimate consumption (Bjerg, 2008). Contrary to the received opinion that the enjoyment of the drug user undermines desire for other pleasures and things (Bjerg, 2008), the symbolic order inhabited by Stevenson's fictive being manages to overcome psychoactive drug domination and maintain the positive self-representation of "socially integrated drug users" (Rodner, 2005).

Like Stevenson, we propose a homo duplex. Our model of the self is one that is both alert to convention and fearful of stigma should the "fiend", the illicit drug taker, be discovered. If the stigmatised self, Hyde, were revealed, his/her civil death would ensue. Hyde would have won, but at a cost. The tenability avoiding this perilous outcome supports the thesis that the physiological effects of drug taking do not dominate behaviour and that cultural factors inform outcomes (Shewan and Dalgarno, 2005; Weinberg, 2002). Sociological analyses of drug addiction propose that to assist addiction recovery, we should emphasise it as a project of activating a self-identity which is integrated (Weinberg 2002). Neale *et al.* (2010) observed the difficulties faced by the users during recovery processes attempts to reclaim and restore an unspoiled identity.

This paper focusses on the illicit drug use of a neglected hidden population of drugs takers who are not formally identified as problem users. The non-captured drug taker has neither sought treatment, nor been imprisoned for either drug possession or unruly behaviour while intoxicated.

The intentionally unseen (McPhee, 2013) suggested that there were hidden users "out there" unknown to services and the police, and even friends and families. This paper explains theoretically how hidden populations use agency as protective factors to avoid becoming known as drug takers by resisting the othering that accompanies how structures and language construct the typical drug user identity as spoiled, contagious, evil and beyond retribution (McPhee *et al.*, 2009; McPhee, 2013).

The research question the study examines is:

RQ1. How and in what way does a climate of moral, legal and medical censure and ensuing societal reaction to the use of certain drugs impact on the social worlds of non-treatment seeking illicit drug users?

We explore the social experiences of hidden and unseen drug users who live through their careers as drug takers in a moral universe from which they would be excluded if their "clandestine" identity were revealed to "outsiders" (Becker, 1963). The specific empirical objectives were to explore the participants' subjective experiences of being hidden drug takers and how these intersect with their status as otherwise "normal" and productive law-abiding citizens. Emphasis rests on the function that drug use plays in their hidden social identity. To that end, our analysis explores the membership of sub-cultures deemed deviant by society (Parker *et al.*, 1998; Hammersley, 2011; Hammersley *et al.*, 2001).

Orne (2013), using Goffman's classic work, *Stigma: Notes on the Management of a Spoiled Identity* (1963), found queer young people capable of maintaining a "double consciousness" by using management strategies, for instance, by either disengaging or by tailoring their identity to conform. The "discredited" individual conceals stigma by covering and preventing the stigma trait from "looming large" and being a focus for interactional attributions. The aim is to prevent a loss in status and, worse, criminalisation. Goffman (1959, 1971) argues the ability to present oneself as a moral actor is crucial in enabling participation in, and maintaining full membership of, the moral societal community. He coins the notion "career" to apply to any practice that implies a career path of a social identity. Goffman's career concept (1961, p. 119) refers to "any social strand of a person's course through life". He argues progression through life as a social actor is a career. The "backstage" in his dramaturgical model of the social refers to what is hidden in contrast to the "frontstage", which is public. Goffman's multi-plex view of identity is a presentation in response to the perceived demands of everyday life including normative expectations that others may hold.

"Hidden populations" is a euphemistic phrase often applied by convention to marginalised groups, i.e. homeless people, criminals, sex workers and class-A drug users (Frank and Snijders, 1994; Griffiths *et al.*, 1993). Shewan and Dalgarno (2005) argue that drug research

ought to incorporate hidden populations and desist from concluding that the chemical effects of drugs are always addictive and destructive. In their study of heroin users, they propose destructive outcomes emerge not necessarily from drug toxicity, but from the attendant psychological and social effects of drug taking; culture and psychology are potential causal factors responsible for adverse effects (Golub and Johnson, 2005). Heroin can be used over considerable duration and by those who neither have contact with agencies, nor criminal records. On the contrary, most of their experienced user sample were in employment and Higher Education. Weinberg (2002) argues against the received medicalised position that drug addiction and its effects are located in pathological deficiencies. Instead, Weinberg (2002) proposes that key elements of addiction are cultural and social transgression which transmits the meanings of the addiction process – which some argue in the case of "methadone maintenance" equates to a bio-political discipline (Bourgeois, 2000).

Axel Klein (2011) argues that the symbolic and ideological functions of drug policy triumph over scientific objectivity. Some researchers are sceptical about drug policy objectives (Berridge and Thom, 1996; Seddon, 2005, 2011; Seddon *et al.*, 2008; Duke, 2001; Ashton, 2008). Critics describe the tendency to play down value conflicts and power struggles that occur between various agencies of social control, particularly medicine and law enforcement, which create factions and opposing stakeholder interests. The possession of drugs that have been defined as illegal breaks the law within the confines of the UK Misuse of Drugs Act 1971. Criminalising drug takers, and medicalising the use of drugs, valorises the abstinent identity of non-drug users as a norm, thereby creating binary categories of drug users and non-drug users and, by extension, good healthy citizens and bad unhealthy criminogenic citizens (Brown, 2007; McPhee, 2013). Since the formation of the UN conventions in 1961 and 1971, the use of certain drugs, i.e. opiates, cocaine and cannabis, has been linked to addiction, crime and deviance (Szasz, 2003; Goode, 2006). Weinberg (2002) argues that we must "de-naturalise addiction" and foreground its sociology. In this vein, Hammersley (2011) argues research ought to shift away from theorising "drug-users" and instead explore "drug-use" as a strategy for avoiding medicalising this field.

Methodology

Using methods employed by McPhee (2013) and informed by the work of Pearson (2001) provided an "emic" and an "etic" view (Headland *et al.*, 1990) in identifying and recruiting participants. That view is articulated within the frames of reference of an insider, as opposed to a purely "etic" framework of understanding from the perspective of the "objective" outsider. As part of a wider study on drug use and drug distribution, we included observational field notes at events where drug taking occurred, semi-structured interviews and informal discussions with over 30 drug users at varying "career" stages. Transcripts and summaries of 24 of these have been produced that document their views. Salient extracts from participants are included in the paper to provide insights in relation to issues surrounding the research question.

Recruitment and inclusion exclusion criterion

Initially four "gatekeepers" provided researchers with an introduction to drug users who fitted the inclusion criteria. They had to have been current or former users of illegal drugs and not to have had any contact with any treatment agency or service. Potential participants were excluded on the basis of having had experience of formal treatment or contact with the criminal justice system for drug offences.

After gatekeeper networks had been exhausted, the researchers reverted to a wider chain referral network to recruit further participants. This method of selection via the first social gathering to recruit participants yielded several suitable participants. This method of selection involved mentioning exactly what type of user the researchers were interested in, for example, an equal number of male and female users[1] and a large enough sample of opiate experienced users.

Anonymity was assured and identifying details (known only to researchers) were kept separate from recordings and transcripts. Interviews lasted one hour and took place in a private room, ensuring confidentiality. Using a digital recorder, participants were asked to explore their experiences of using controlled drugs. Data saturation occurred after twenty four full

transcriptions were typed and coded descriptively. A selection of transcripts was read to allow the main (sub)themes to emerge. The method of structured thematic analysis using inductive and deductive processes was used (Neale, 2016). After a coding structure was compiled, all transcripts were read and analysed using this method.

Findings

Table I documents drug types and the frequency of use. Table II indicates demographic details of participants documented at the onset of the semi-structured interviews. Information regarding age, residence, age at first drug use, age they first injected drugs, current status and, in particular, whether they had ever used heroin, a drug particularly feared and demonised, is included.

The strategies participants used to remain hidden included identity rejections, identity exchanges and identity concealment.

Identity rejections

Problematic drug users are most associated in stereotypical constructions of user identities as heroin injectors, or heroin injectors in waiting. This was a stereotype firmly resisted by participants. Gilbert, an intermittent user of several drugs including MDMA and ketamine, described "problematic users". This was an identity he rejected:

> The lowest of the low. They don't work, get by in life on drugs and that's wrong. (Gilbert)

When asked to characterise traits and qualities which signified being a problematic drug user, Alison stated:

> Out of control, promiscuous, [selfish], losing control […] the way they view things [results in their] social network disappear [ing]. (Alison)

Alison's statement supports literature in that recreational users are at risk of becoming problematic users, should sufficient and continual exposure to drugs occur. This view was consistent among all opiate naive participants and fits with wider public discourse. Yet, this was not a view shared by opiate experienced participants. Kilroy presented a more nuanced opinion whereby he did not consider the drugs themselves to be the main variable resulting in problematic use:

> If you've got a coke addiction then you've got to be a high-flyer, you've got to be pulling in the money. I don't see those types of people in a sort of greasy-haired spotty way as I would imagine heroin users, junkie[s]. (Kilroy)

Table I The research participants

	Number
Sex	
Male	12
Female	12
Age	
20+	06
30+	07
40+	08
50+	03
Drug use pattern	
Abstinent	02
Intermittent users	17
Daily users	05

Source: The intentionally unseen research participant interviews

Table II The research participants' demographic data

Pseudonym	*Age*	*Sex*	*Area*	*Employment*	*Have children*	*Accomm*	*Qualification*	*Drug 1*	*Drug 2*	*Used heroin*
Isabel	35+	F	E	Self-employed	Yes	Owned	HNC	Cocaine	GHB	No
Silvia	40+	F	E	Self-employed	Yes	Rented	Degree	MDMA	Alcohol	No
Robert	35+	M	E	Self-employed	No	Rented	C & Guilds	Cannabis	GHB	No
Alison	35+	F	E	Student	No	Rented	Dip.	MDMA	GHB	No
Kirk	52	M	I	Self-employed	No	Owned	Dip.	Cocaine	MDMA	No
Karen	34	F	E	Catering	No	Rented	HND	Cannabis	MDMA	No
Rob	45	M	E	Catering	Yes	Rented	HND	Cannabis	MDMA	Yes
Gilbert	26	M	G	Engineering	No	Rented	MSc	Cocaine	MDMA	No
John	45+	M	G	Self-employed	Yes	Owned	Degree	Cocaine	NPS	No
Donald	50+	M	I	Emergency services	Yes	Owned	Degree	Cannabis	MDMA	No
Jamie	25	M	G	Builder	No	Owned	C & Guilds	MDMA	Cocaine	No
Chris	26	M	G	Insurance	No	Rented	Higher	Cocaine	MDMA	No
Ronald	52	M	I	Risk management	Yes	Owned	Prof. qual	MDMA	Cannabis	Yes
Colette	25	F	G	Office	No	Rented	Degree	Cocaine	Ketamine	No
Juliet	24	F	G	Office	No	Rented	A level	MDMA	Cocaine	No
Mr B	26	M	G	Landscaping	No	Rented	GCSE's	alcohol	Cocaine	No
Renee	32	F	E	Unemployed	No	Rented	Dip.	NPS	Ketamine	Yes
Mary	41	F	B	Self-employed	No	Owned	None	MDMA	Cannabis	Yes
Mr K	42	M	B	Caring profession	No	Owned	Degree	Cocaine	Cannabis	Yes
Millie	49	F	G	Media	Yes	Owned	MSc	Cannabis	MDMA	No
Mr HM	40	M	G	Caring profession	Yes	Owned	SVQ3	Cannabis	MDMA	No
Helen	35	F	E	Student support services	Yes	Owned	HND	Cannabis	MDMA	No
Kath	35	F	E	Catering	No	Rented	HND	Cannabis	MDMA	No
Yvonne	29	F	B	Unemployed	Yes	Rented	None	Cocaine	MDMA	Yes

Note: New psychoactive substances ("Legal Highs" or "Chemical Highs") refer in both instances to Mephedrone or other synthetic cathinones

Kilroy drew attention to economic resources, and other types of capital, that individuals may have at their disposal. Kilroy used this as a tool for measuring what is, or is more likely to become, "problematic". Addiction is more than drug exposure alone. Rather a user's economic situation may be an important factor in influencing drug choice, as well as consumption method and ensuing consequences. In general, participants repeated and endorsed perceptions that heroin users, and more so injectors, were "untrustworthy", and different from their own sensible controlled use (McPhee, 2013). Significantly, some participants considered addicts as biologically different from non-addicted users. Juliet argued some are "born addicts", alluding to the phenomenon known as "crack baby syndrome" when referring to "heroin bab[ies]":

> Some might have been born […] a heroin baby and they've got it in their blood. (Juliet)

Isabel further emphasised the point that addiction is inherited, and viewed addicts as having:

> […] a tendency to be schizophrenic, so they've got that imbalance in their head. I don't think these drugs will necessarily […] give you psychological problems but if you have that gene within you [beforehand] then that might be the thing that sways it. (Isabel)

Leshners' (2000) hijacked brain theory likewise suggests addiction is primarily biological, and recognised or diagnosed by a loss of control over use. A significant proportion of participants described the connection between addictive drugs, for example, heroin, with an innate addictive nature, as being likely to result in problematic drug use:

> [problematic users] just wait for their next dole cheque or wage to get more drugs. That is somebody who lets the drug use them rather than them using the drug. (Robert)

Robert, a former heroin user, argued that for some users, they have little or no control over their desire for drug consumption, resulting in problematic usage. While most shared this view, a few opiate naive participants knew heroin users who did not neatly fit such stereotypes, despite still adhering to general stereotypical narratives in their wider discussion.

For most participants, factors of being an innate "addict" and "drug addictiveness" were considered the primary causal factors in defining and differentiating between addiction and controlled use. The creation of such boundaries enabled participants to identify themselves as different from "addicts" and thus reject a drug addict identity. Addicts were described as easily identifiable, not only because of their mode of dress[2], accents or visible characteristics. In being visible, heroin addicts are vulnerable, and open for identification as "The Other" (Bauman, 1988). Thus, they were considered part of a deviant sub-culture, easily recognisable and, subsequently, instantly subjected to societal scorn. Ronald explained how heroin and crack cocaine are more likely to result in problematic use:

> Depends on what kind of drug user that you're talking about […] I've not come across a decent heroin addict yet, they would rob you. Crack-heads [also], would rob you. (Ronald)

Literature reveals these two drug types as particularly addictive, with sufficient exposure. However, there is also literature that has found users able to control the use of such drugs (Hammersley and Ditton, 1994; Shewan and Dalgarno, 2005) and challenges the view that drug exposure is a sufficient causal factor resulting in loss of control, and risk of addiction. However, such evidence was unknown to participants, who generally repeated the views disseminated via "drug talk"[3]. Yet, there are several scholars who have challenged the "drug talk" discourse, arguing addiction to be part of a social construction. Consequently, any efforts to locate the cause of habitual drug use in the user or in the drug is a somewhat pointless exercise. McPhee (2013) notes there is substantial evidence from statistical relationships between dislocation and social problems like alienation, anomie, crime and drug addiction. Yet, participant Mary, a regular cannabis user and occasional opium user, who worked in media, did acknowledge such labels were somewhat socially constructed. Mary had recently conducted research on poverty, and found while many individuals in deprived areas wanted to cease taking drugs, much of their root problem stemmed from deeper non-drug related issues:

> [I] was interviewing kids […] in prison [and who had] drug habits […] [yet] not that it isn't a drug addict's fault, [but] if [they] had been taken out of poverty and [social exclusion] and [given] some jobs [they may not have consumed drugs]. (Mary)

This view was expressed by a small minority of participants. The majority tended to view the cause of addiction in biological or psychological explanations and ignored environmental or structural factors related to inequality and deprivation. Yet, given that there were a variety of competing explanations for addiction – biological, structural, psychological – all expressed by the participants, merely highlights the complexity of the debate in both the academic and public arena, as to what addiction actually is, and what policy/approach might best suit in addressing such issues. Indeed, Yvonne, who had tried heroin and lived with a regular user, discussed how several of her social group became addicts while others did not:

> [heroin] was pants. The experience wasn't as good as it was made out to be […] I just expected something more like when you take E[cstacy], you feel wonderful […] [heroin] just wasn't that great. (Yvonne)

When probed as to why she did not become an addict and others in her social circle did, Yvonne stated that other things such as "work", "friends" and "kids" were simply more important. It would seem that when other things are held in higher esteem than the use of drugs, then drug problems are less likely. What is certain is that numerous risk factors beyond exposure are important in contributing towards problematic usage.

Identity exchanges and negotiated loss of control

Participants discussed how drugs were not only an enjoyable experience, but in many cases drug taking proved somewhat functional in that it allowed participants to experience a temporary "loss of control" and sense of escapism. Rather than using terms like "loss of control" in the strictest sense, participants emphasised that such behaviour occurred within created risk boundaries. They preferred to describe themselves as creative risk takers, as opposed to irresponsible hedonists:

> The whole point of taking drugs with me is I like to get really high to a point, where you're not coming down for a while and you feel great. (Ronald)

Like Ronald, most participants gave similar reasons for drug taking, whereby they sought to temporarily exchange the contingent identity for a somewhat controlled hedonist pursuit. Participants adopted a language which described their own drug taking as having been risk assessed and thus responsible. Participants actively rejected stereotypical descriptions of hedonism. Temporary, and responsible, loss of control meant that participants, as with Ronald, did not put their "master-status" at risk. Participants rejected the imposed boundaries by way of addiction discourses, which emphasised drug use as out of control, and risk of addiction. Rather, by making loss of control about pleasure, participants like Ronald exercised their individual agency, temporarily exchanging one identity for another. Drug taking was therefore typically viewed as personal "me" time, whereby the working day ceased, and recreation began. Silvia explained:

> It (drug taking) is a reward and a kind punctuation, a knocking off. (Silvia)

Drugs are used to symbolically create atmospheres/environments that are leisurely, and like in all other human activity, there are serious users, with a high degree of knowledge, intermittent users, and "(drug) tourists", who come and go, but do not actively identify with the "native", or regular, user.

Karen, a daily user of cannabis, and former opiate user stated:

> Drug user is a pretty vague term for a pretty broad spectrum. Which end of the spectrum should I pick […] habitual user or recreational. (Karen)

As Karen notes, drug use exists on an ever-shifting continuum, making "labelling" problematic if at all possible. Interestingly, why participants first started using drugs, and their reasons for continuing, changed little. Ultimately, drug use was considered to aid sociability and enjoyment in the company of like-minded individuals. This finding is of course contrary to the typical service user narrative and discussion of drug careers which end in abstinence or death. As this narrative was distinctive, it was therefore important to explore the mechanisms by which participants separated "recreational" from "problematic", and through which status was achieved and communicated, exercising control. The purpose or function of the narrative was to create a separate identity, functional insofar as it distanced the participants from the stereotypical problem user, and perhaps also the typical problem users' lack or loss of agency, once labelled and "outed" as a problem user akin to Stevenson's depiction of Mr Hyde.

Identity concealment

Three distinct forms of identity concealment, through which participants also derived their sense of normality and social inclusion, emerged from the data. These were the "worker", the "parent" and the "hobby enthusiast". Ronald, a worker, stated:

> I'm just a normal functioning human being. I've got friends […] some of them are very successful and run really successful businesses and they take drugs like myself, just as and when, it's not something they are doing every day. (Ronald)

Ronald normalised his use by categorising it as something which most of his social circle practise. By emphasising that this did not affect his capacity to be an effective worker, Ronald neutralised potentially stigmatising labels. Donald went a step further, categorising drug taking as something the majority of people do, and used his workplace as a representative sample:

> Most folk I know take drugs, illegal drugs of one sort or another […] probably a quarter to a third of the people [in the workplace] take drugs. (Donald)

Donald's view that the use of some illegal drugs as essentially normalised, or accommodated, was quite contrary to how drug takers are typically characterised in government policy documents, and perceived by "moral entrepreneurs" (see Becker, 1963). While this situation was possibly unique to Donald's workplace, or even an exaggeration, it was a finding which supports the narratives of other participants. Donald explained that users may acknowledge each other's drug taking at his place of employment, but it was concealed from others out with for fear of reprisal, stigma or persecution:

> I mean one of the lads; his wife does not know anything of his coke use. (Donald)

Donald referred to this particular friend as "Escobar-veneer" because he consumed so much cocaine yet hid this behind a "veneer" or cover of respectability that even significant others did not know. Participants spoke at great length about concealing their alter ego identity even during recreational times, and while they considered drug taking was very much common practice amongst most of their peer networks, the governing societal discourse meant that they still had to conceal it from others, including loved ones. This was particularly true for those who were parents. Juliet explained why one of her friends can never become one "in the know" regarding her drug taking:

> We have so much in common; I could talk to her all day. But I would never bring her on a night out, as I've heard her comment on people taking drugs. Because I think she is so against them, she believes it's a bad thing. Although we are friends she is so against it so I choose not to tell her anything. (Juliet)

Thus, there was considerable risk attached to drug use disclosure in certain workplaces. Colette explained:

> You couldn't just talk about this to anybody, like people in your work or whatever. (Colette)

"Child protection" social policy is underpinned by the discourse that drug using parents are more likely to practise poor parenting, and that their drug wants may supersede their children's needs (Barnard and McKeganey, 1999). Such beliefs stem from temperance dogma[4]. Several cannabis using parents discussed how they limited consumption to when their children were in bed or staying at a relative's/friend's house. For parents who consumed drugs such as ecstasy or cocaine, this was typically limited to weekends, again, when children were being supervised by other adults.

Being a parent meant negotiating the identity nexus of parent/user. Thus, one identity was often decanted for another depending on the circumstances and setting. As such, drug use was risk assessed, controlled and typically confined to "recreational time". It would even impact upon levels and duration of consumption during these times. Isabel explained that she was a parent of a young child, and how she managed the risks of intoxication, and loss of control:

> With a young child in the group that we socialise with, I always take less than them and am always aware that I've got to leave. If they are going to start taking an E pill usually to their one, I take half […] I've got to get home and be responsible and all that. (Isabel)

Isabel pointed out that even during the identity exchange which occurs in recreational time, she had to be aware of the impact consumption may have on her other identity as a parent, and thus put in place certain risk boundaries. Those who adopted the "hobby enthusiast" identity as part of the concealment from law-abiding citizen to drug user included a variety of activities. These ranged from being a "petrol head" who spent time racing cars and bikes, to "club tourists" who would use drugs at certain clubs/parties or other social events, to those who engaged in sports to mitigate the negative effects of prolonged use of stimulant type drugs. These responsible risk assessors required safe places where they could express this aspect of their personal identity with like-minded others, where there appeared to be a group cohesion, as those who "use" and those who are not part of the social worlds of the purposely unseen. Drug use for club tourists, particularly older participants, was seen as a way of tearing down social barriers like class and other subjective divisions. Harry explained:

> I met a lot of people through it (MDMA) as well too, clubbers, people that I would probably not normally have a great deal in common with, from very affluent backgrounds, when we were doing the club thing. (Harry)

Harry indicated that drug use at certain social events was a way of bonding users who would usually operate independently of one another. Drug-taking environments were largely perceived as classless environments where social distinctions were created through having knowledge about drugs, as opposed to what one consumes, owns or has achieved. The clothes, music, lifestyle all interacted to create aspects of an identity that allowed a sense of belonging, where drug taking was not condemned as irresponsible, but tasteful and even essential to the enjoyment of music. Yet for others, like those who had a predominantly sporting identity, such as Kirk (a rambler and climber), or John (a martial arts expert), drugs fitted into their lifestyles better

than other socialising substances like alcohol. Kirk explained why he tended to favour illegal drug use over alcohol consumption:

> I hate anything that gives me a hangover […] it doesn't suit what I do with the rest of my life […]. Me and my [friend] were into climbing and we were coming back from weekends, totally knackered and we used to drink in a boozer and we heard about sulph or wiz (amphetamine sulphate) that gave you a bit of a buzz. It meant you were wide awake, and we thought it would match our weekend's hill-walking, climbing. (Kirk)

These participants, like Kirk, enjoyed risk, and considered alcohol as "empty carbs" or giving participants a "hangover". Stimulant drugs were seen to fit their particular lifestyles better. The use of the stimulants amphetamine and cocaine enabled Kirk and his friend to pursue energetic pastimes. Several participants indicated that drugs were functional, and not just in the social nexus. Sport tends to overall be in general a group/social activity to one extent or another. Identity concealments and exchanges, as it would seem, are possible due to the blur in the discursive divides between a non-user, user, recreational user and problematic user, and the ability of the users to successfully switch identities, and exercise an agency unavailable to know and "outed" problem users. Thus, for the participants, drug use was merely one part of an eclectic identity. In rejecting stereotypical user and problem user labels, they avoided negative social reaction and being discovered or labelled as a "problem" drug user. It was this fear that motivated them to remain purposefully hidden and unseen.

Discussion

This paper contends that the personal identity discourse of participants is an attempt to align themselves with non-user identities to prevent socially damaging stigma. Participants presented themselves as part of moral social groupings, while simultaneously engaging in certain behaviours routinely scapegoated and stigmatised.

The participant responses suggested that the functional and instrumental value of drugs was the "nexus" around which a significant part of their hidden social life existed. Consumption of drugs was often confined to weekends and social occasions and the use of stimulants in particular was considered purposeful insofar as they allowed some users to stay awake and/or consume alcohol without succumbing to its depressant properties and exhibiting a loss of control.

If the experiences and perceptions of our participants potentially reflect wider norms and a significant proportion of Scotland's population have experienced drugs, or know people who have, who did not become problem users, then it could be argued that we reconsider conceptualising drug users as "offender-addicts in waiting". In the past, a "drug-user" was definable as a member of a deviant sub-group (Becker, 1963). It is without doubt that adopting an "addict" identity or being known as an addict is a radical shift in individuality, and highly stigmatised (Radcliffe and Stevens, 2008). Common misperceptions of drug users construct stigmatised identities based on misidentifying drug of choice with pathology (Anthony *et al.*, 1994) or on their route of administration (e.g. junkies and injectors) (Samaha and Robinson, 2005; Radcliffe and Stevens 2008), or their type of crime (drug traffickers, dealers, etc.) (Yacoubian, 2001; Galenianos and Gavazza, 2017; European Monitoring Centre for Drugs and Drug Addiction, 2017). We require explanations for drug taking that move away from simple constructions of deviance and labelling. It is no longer appropriate to label drug users as "outsiders" (Becker, 1967), as this is only a small part of their personal and social identity. The management of an aspect of identity, which must be concealed to protect self-esteem and status as "normal", is required (Goffman, 1963).

Identification for the participants in this research was characterised in terms of protecting esteem and managing potential social affronts. Users construct positive identities by rejecting negative aspects of identities that are potentially stigmatising (being a heroin smoker but rejecting emphatically the identity of drug injector). Illicit drug use may serve as a marker of identity boundaries in a way that is potentially misleading. Judgements of similarity to, and difference from, others, which are constructed on this basis, may not work outside the small-scale settings of drug use (Hammersley *et al.,* 2001).

These processes, previously highlighted by the labelling model in the sociology of deviance (e.g. Becker, 1953), are also central to Goffman's interactionism perspective and are useful in the study of identity (Jenkins, 1996). Nonetheless, there has been an increasing merging in the ways in which drug users understand and foreground their status as non-deviant, ordinary citizens and how they are externally categorised (Radcliffe and Stevens, 2008; McPhee, 2013). Signification, negotiation and categorisation are likely to combine in different ways to produce a range of potential identity constructions. Some studies find that users who view drugs as a large part of their lives struggle to maintain or develop other aspects of their social identity, such as parents (Taylor, 1994), students (Brewer and Pierce, 2005), masculine men (Caceres and Cortinas, 1996) or non-addicted, successful drug dealers (Bourgeois and Pearson, 1995; Schensul *et al.*, 2005). Bauman (2000) helpfully summarises the complexity of this situation by stating:

> perhaps instead of talking about identity, inherited or acquired, it would be more in keeping with the realities of the globalising world to speak of identification, a never ending, always incomplete, unfinished open-ended activity in which we all, by necessity or by choice, are engaged. (Bauman, 2000, p. 152)

It is evident that our research participants manage clandestine identities by disclosing their drug use only to others who they believed would not condemn them. The interviewees expressed frustration at how their lifestyle choices were perceived by "other" drug users (alcohol users in particular), in government policy documents and in the drug talk which underpins addiction discourse, and supporters of drug prohibition, as a moral battle.

Conclusion

Jock Young (2004) argued that the study of deviance disregards three major problems in its measurement. These are the problems of representativeness; of the plurality of definition; and claims to truth based on the previous two categories. The term "drug user" is a signifier saturated with meaning and symbolism immediately brought into play when this label is used. In one single concept, that of the "addict offender", and the perceived inevitable "loss of control" that results from exposure to drugs, we find embedded a simple, static explanation about what drugs are, and the power they have to remove reason and rationality. The pejorative terms used to denote drug problems such as "abuse" and "misuse" and the complications associated with drug consumption by social actors signify a universal view of users not as human beings, who choose to do something that is condemned, but as "others", a force that terrifies by contaminating a good ordered society. Drug "addict", "junkie", "problem user", "offender", "waster", "poor parent" and numerous other terms within this lexicon render into thought drug users as different and outside of a moral community.

Research into drug use from the beginnings of the twentieth century onwards concentrated on the addict as different, and linked drug use to crime and pathology (Glassner and Loughlin, 1987; Alexander, 2008). The large body of social science research which challenges "dope fiend" mythology is little known by the public and is available only in specialist texts and in academic institutions.

This paper introduces a new concept into the lexicon of social research, that of the "purposively hidden drug user". We allude to this concept in our reference to Stevenson's novella. Such a term allocates some power to drug users labelled deviant due to their choice to use illegal drugs, but who maintain the clandestine identity of a Mr Hyde. The terminology endorses the active decision of these research participants to remain part of a wider community that rejects the use of drugs as immoral and criminal, and how they manage to maintain a clean identity by intentionally concealing deviant activity by veils of respectability and selective conformity, exercising individual agency.

The data indicate that the use of illegal drugs has become accommodated for these participants; however, users are routinely stigmatised, and all use is thus linked to problem users, who are most often domiciled in pockets of deprivation in the UK, vulnerable and likely to be caught within the criminal justice system as "drug offenders", unable to exercise agency as active subjects. This allows the discursive gaps between the stigmatised outsider, the "offender in waiting", and the illicit, illegal drugs user to be closed, and creates self-fulfilling prophecy. Golub and Johnson (2005) argue that drug use in the US inner-city involves relations between drug sub-cultures and individual identity development. Pressure to belong to street-cultures in the US

context means the agency of those with limited attachment to conventions may not mature out from using drugs such as heroin, crack and marijuana. Golub *et al.* refer to this trajectory as "sub-cultural inertia". This meaning of the latter connects with the persistence of the stigmatised outsider whose connectedness to mainstream norms appears ambivalent. Their "offender-in-waiting" status is sustained both by a tenuous attachment to convention and the strength of the pull of their sub-cultural affinities.

The analysis of our data revealed the techniques the participants utilised to remain purposely hidden, are due to their abilities to exercise agency, and avoid such "disabling" labels, with attendant social affronts, stigma and discrimination (McPhee *et al.*, 2013). Three themes of identification were discussed in terms of, first, identity rejections: referring to how the participants viewed themselves as essentially normal, and rejected the addict identity using several arguments with which to delineate identity difference, including biological arguments – addicts were born not made – that some drugs, such as heroin, inevitably caused problems, although this was only true of the opiate naive; and structural factors as causal to use and problems. The second is identity exchanges: the participants were able to voluntarily engage in a temporary loss of control, which as volitional separated them from problem users. The third is identity concealments: referring to the necessity of concealing an identity as functioning drug users to preserve an untainted identity. Several participants were parents. This paper discovered techniques used by participants to neutralise risk by creating boundaries that separate "moderate" and "compulsive use" patterns. Rodner (2005) argues drug users' positive self-representations in Stockholm giving rise to their "drug-wise" self-control and knowledge about drugs is enabling of their capacity to draw boundaries between themselves and other "deviant" drug users, and to sustain responsible lifestyles outside of their drug-taking choices. Akin to the research participants, through the power of individual agency, they challenge the prevalent construct of illicit drug users as helpless victims of addiction to evil substances.

The data presented in the paper are consistent with the narratives we have identified in the qualitative literature. The data endorse the view that the consumption of illicit leisure activity is not confined to any one subculture. Young (2003) argued that even socially excluded groups, such as problem drug users, can embrace consumption as a way out of their economic and social situation. The argument is that drugs and crime are rational responses to a culture that views those who do not conform to the "norms" of abstinence from illegal drugs, in particular heroin users, as unproductive, irrelevant and disposable humans lying beyond an "iron cage" of rationality.

Max Weber famously argues that this thesis typifies the morally dutiful disenchanted landscape of Western capitalism. Bourgeois (2000) argues that even in methadone interventions designed in the US to treat heroin addiction, a newly designed iron cage is imposed, and the one which worsens the cultural circumstance of those subjected to this "moral discipline". Despite the methadone user being classed as "patient" not "criminal", not only does this dependency cause anger and depression, but it also impacts their cultural integration and ability to recover from stigma. Judged as a type of iron cage, the methadone clinic, as Bourgeois (2000) discovered, merely re-distributes an outsider illegitimacy in order to make these users more manageable to policing. What Hammersley (2011) calls a "hidden disability" remains but these US heroin addicts are also estranged from the street. Through being able to strategically conceal their illicit drug-taking activities, our sample manages a "hidden disability" without status loss or the stigma of a spoiled identity. Their drug use appeared to be one form of an identity marker whose meaning was arguably helpful to their holistic wellbeing.

Notes

1. Examining sex differences in detail was not a research objective.
2. That is, wearing long sleeve shirts and jackets, which helped cover the "track marks" on their arms from regular injecting.
3. A reference to temperance discourses that legitimise demonising users of illegal drugs for choosing intoxication over abstinence.
4. See the classic satirical print titled "Gin Lane" by William Hogarth 1751, available at: www.britishmuseum.org/

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Substance use by social workers and implications for professional regulation

Niki Kiepek, Jonathan Harris, Brenda Beagan and Marisa Buchanan

Abstract

Purpose – *The purpose of this paper is to explore the prevalence and patterns of substance use among Canadian social workers. With legalisation of can professional regulatory bodies are pressed to consider implications of substance use for their members.*

Design/methodology/approach – *An online survey collected data about demographics and substance use prevalence and patterns. Statistical analysis involved pairwise comparisons, binary logistic regression models and logistic regression models to explore correlations between substance use and demographic and work-related variables.*

Findings – *Among the respondents (n = 489), findings indicate that past-year use of cannabis (24.1 per cent), cocaine (4.5 per cent), ecstasy (1.4 per cent), amphetamines (4.3 per cent), hallucinogens (2.4 per cent), opioid pain relievers (21.0 per cent) and alcohol (83.1 per cent) are higher than the general Canadian population. Years of work experience and working night shift were significant predictors of total number of substances used in the past year. Use of a substance by a person when they were a student was highly correlated with use when they were a professional.*

Research limitations/implications – *Prevalence of substance use among social workers was found to be higher than the Canadian population; potential due to the anonymous nature of data collection.*

Originality/value – *This study has implications for social conceptualisations of professionalism and for decisions regarding professional regulation. Previous literature about substance use by professionals has focussed predominantly on implications for increased surveillance, monitoring, and disciplinary action. We contend that since substance use among professionals tends to be concealed, there may be exacerbated social misconceptions about degree of risk and when it is appropriate to intervene.*

Keywords *Canada, Social workers, Substance use, Policy, Professional regulation*

Paper type *Research paper*

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Background

Our research was designed to explore the nature and prevalence of substance use by professionals in Canada at a historical time of legislative changes to regulation of cannabis distribution and use. This paper presents the findings of a Canadian survey about prevalence of substance use in relation to factors in the work context (e.g. profession-related stressors) as reported by social workers. We define substances as all chemicals that alter brain function, affecting consciousness, mood and perceptions. They encompass licit drugs (e.g. caffeine, alcohol, over-the-counter medication), prescribed medication (e.g. oxycodone, benzodiazepines), illicit drugs (e.g. marijuana, cocaine, MDMA) and traditional healing plants (e.g. peyote) (Kiepek and Baron, 2017). Professionals are typically members of profession-specific societies, associations, colleges and/or regulatory bodies, subject to codes of professional ethics or codes of conduct and/or subject to professional licensure or accreditation.

Substance use is not conceptualised in this study as inherently problematic; rather a wide range of patterns of use were anticipated, with some patterns of use being widely accepted and condoned within the professions (Kiepek and Beagan, 2018). This research was grounded in an effort to minimise the reification of assumptions that substance use poses individual or social risk, particularly among professionals who are often responsible for clients or patients.

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With recent legalisation of cannabis in Canada in 2018, professional regulatory bodies are pressed to consider implications for their members. A majority of existing research about substance use by professionals examines the prevalence of use, without examining personal, professional or contextual factors that may relate to patterns of use (Kiepek and Baron, 2017). Qualitative research about the use of substances by professionals predominantly draw participants from addiction service settings or regulatory discipline boards (Kiepek and Baron, 2017), a group likely to have already experienced discernible negative work-related outcomes. Those results may not be generalisable to the typical population of professionals who use substances.

There is little peer-reviewed evidence about use of substances by social workers. Aspects of social work set it apart from other professions, which may shape substance use experiences. As part of professional socialisation, Canadian social workers are taught to be "social justice professionals" (Canadian Association of Social Workers, n.d.-b). There are dual expectations that social workers will foster a "positive image of the profession" (Canadian Association of Social Workers, n.d.-a) among the public while guiding "policy makers to understand the impact of policy on social justice" (CASW Stat Plan). Social workers simultaneously uphold social values and images of what it means to be a professional, while working to critique social policies that function to create inequality and disadvantages. Conforming to social ideals of professionalism while critiquing underlying values and systems that shape ideals and expectations may impact choices about substance use, perhaps contributing to practices that are less constrained by conventional values and norms.

Professionals are often expected to "bracket" or set aside their personal values, beliefs and experiences in order to be professionally "objective" and value-free. However, lived experience of diverse life events is understood to draw individuals to the field of social work and enrich their work as professionals (Gilbert and Stickley, 2012; Goldberg *et al.*, 2014; Newcomb *et al.*, 2017). Social work education entails extensive and rigorous acquisition of knowledge and skills, but lived experience of struggles such as poverty, violence, mental health issues, addictions and so on may help social workers to achieve deeper connections with clients and deeper understanding of their issues, potentially facilitating more empathic responses (Gilbert and Stickley, 2012; Newcomb *et al.*, 2017). Canadian social work programs also have a reputation for more inclusive affirmative action and equity admission policies than other professions, which may make it more appealing for those who have backgrounds (e.g. familial) and experiences typically under-represented in the professions.

Substance use is hypothesised to serve as a form of self-medication or self-management in response to stressors (Lillibridge *et al.*, 2002; Merlo *et al.*, 2013) and mental illness (Bravo *et al.*, 2017; Brière *et al.*, 2014; Hogarth and Hardy, 2018). Social workers may be subject to high stress, particularly given the likelihood of working with clients who experience trauma or crisis. Compassion fatigue may result from intensively supporting others and witnessing sometimes devastating outcomes (Bourassa, 2012; Wagaman *et al.*, 2015). Information about personal substance use or mental health among social workers is scarce, though previous research indicates high prevalence of distress and mental health symptoms. One study found that 47 per cent of social workers in England and Wales received scores indicating a potential psychological disorder using the General Health Questionnaire (GHQ-12) (Evans *et al.*, 2006).

Among the professions in general, research has shown mixed results regarding relationships between stressors and substance use. While some studies have found no or weak correlations (Jex *et al.*, 1992; Maddux *et al.*, 1986; Watts and Short, 1990; Watts *et al.*, 1991), others have shown weak negative correlations, suggesting substances may provide effective means to manage these stresses (Newbury-Birch *et al.*, 2002; Newbury-Birch *et al.*, 2001).

Methodology

Recruitment

Recruitment was targeted at Canadian social workers, occupational therapists, lawyer and accountants. Advertising differed between organisations, resulting in higher response rates from

social workers and therefore the analysis was conducted specific to social workers. To participate in this online survey study, respondents had to be a professional, reside in Canada and be 19 years or older. Previous or current use of psychoactive substances was not an inclusion criterion. A recruitment notice was emailed to all members of the Canadian Association of Social Workers (CASW) ($n = 18{,}801$) once during social work month in 2017. Given financial costs associated with advertising, contact was limited to once. The CASW e-mail list is comprised of members who are or were social workers in Canada and may include few inactive or duplicate accounts. All social workers who join a provincial or territorial social work organisation, with the exception of Ontario and Quebec, are automatically affiliated with the CASW. In British Columbia, membership is optional. Social workers in Ontario and Quebec are offered individual memberships, as the CASW is not in partnership with another organisation in those provinces and therefore membership numbers are low, despite these provinces having a high number of social workers relative to other provinces (personal communication with CASW). In Alberta, membership in the CASW is mandatory and there are relatively more social workers in this province compared to other provinces.

In total, 5,251 members opened the e-mail, 2,737 clicked through to the survey website, and 504 started the survey. In total, 15 people completed the demographics, but did not provide information about substance use, so were removed from the analysis. It appeared that some people may have completed the demographics, and started a new survey at a later time. Of the 5,251 people who opened the e-mail, 9.3 per cent ($n = 489$) engaged in the survey. While the number of responses is sufficient to power the analyses, there is no way to know how response bias may affect the representativeness of the sample, and therefore generalisability of results. This is not an unusual response rate for an external survey (Fan and Yan, 2010).

Instrumentation

The survey was designed using Opinio software and posted online for approximately five months. The instrument was pilot tested with a group of undergraduate research trainees and professional colleagues who completed the entire survey and provided feedback. The finalised survey consisted of three sections: demographics and substances used; effects of substances; health indicators (Patient Health Questionnaire (PHQ-9) and Generalised Anxiety Disorder Assessment (GAD-7)). The length of time to complete the survey depended on the number of substances the respondent had ever used. It would take a minimum of 8 min, plus an estimated additional 2 min per substance. The types of effects documents have been reported elsewhere (Kiepek *et al.*, 2018), and were categorised as feeling (25 emotion-related changes), bodily changes (12 physiological-related changes), thinking (10 cognition-related changes) and doing/performance (21 changes related to engagement, performance or experience of activities). Relationships between substance use and mental health as indicated by the GAD-7 and the PHQ-9 are also reported elsewhere (submitted manuscript). Here, we report on the patterns of use in relation to work context and demographics, particularly highlighting workplace stressors.

Data analysis

In the first phase of the analysis, independent variables likely to be predictive of substance use were identified, based on current literature. A series of pairwise comparisons was conducted to identify highly correlated pairs of predictors (Pearson's correlation coefficient > 0.50). The predictor that was of least interest theoretically was removed. A strong correlation between work experience and age range ($r = 0.778$; $p < 0.01$) was identified; therefore, age range was removed from subsequent analysis. The resultant list of predictor variables included province, work experience, hours worked, total working hours, night shift and crisis response. To avoid small cell sizes, some response categories were collapsed. Provinces were grouped as Atlantic (NS, NB, PEI, NLFD/Labrador), Alberta and other. Hours worked per week, and total hours worked (paid and unpaid work) were collapsed into tertiles.

A series of binary logistic regression models were used to investigate the relationship between the predictors and past year use of substances. Substances were categorised as

prescribed substances (anti-depressants, antihistamines, barbiturates, buprenorphine, Ritalin), hallucinogens (ecstasy, GHB, ketamine, khat, LSD, psilocybin, MDMA, peyote), licit substances (alcohol, caffeine, tobacco), illicit substances (amphetamines, cannabis, cocaine, ecstasy, LSD, psilocybin, melatonin, mescaline, MDMA, methamphetamine, heroin), stimulants (amphetamines, caffeine, cocaine, methamphetamine, tobacco) and depressants (alcohol, benzodiazepines, cannabis, sedatives, sleeping medications, Gravol (dimenhydrinate)).

For each categorical predictor with more than two levels, the most frequently reported level was chosen as the indicator level. Contrasts were made against this indicator level. For example, for the predictor "province," the majority of respondents were from Alberta, so this was chosen as the indicator level, against which comparisons were made for the purpose of calculating odds ratios. Similarly, for work experience the comparison level was 20+ years of experience; for hours worked, the comparison level was 27–44 h; for total working hours, the comparison level was 42–69 h.

A series of logistic regression models were used to generate odds ratios for each substance as a function of specialisation (Hughes *et al.*, 1999). Finally, in order to explore whether any demographics or work patterns predicted total number of substances used in the past year, multiple linear regression was conducted with the aforementioned independent variables (province, years of work experience, night shift, crisis response, hours worked per week, and total productive (paid and unpaid) hours per week).

Findings

Respondents

The greatest number of respondents (41 per cent) was from the province of Alberta, with an additional 24 per cent coming from the Atlantic provinces (see Table I). Few respondents worked in the remaining provinces and territories, two of which (i.e. Ontario, British Columbia) have large populations and large professional bodies. Ages ranged from 19 years to over 70, with age evenly distributed through the three categories. Years of work experience was bi-modally distributed with 37 per cent having 0–9 years' experience (collapsing categories of 0–4 and 5–9) and 33 per cent having 20+ years' experience.

Specialisations were entered as an open-ended response, coded by the first author, and classified into seven subgroups according similar scopes of practice (see Table II). Small cell sizes were avoided to enhance the power of analyses (Joos *et al.*, 2013). Of those who reported area of practice, most worked in mental health and addictions as well as child protection.

Most respondents did not work night shifts (89.6 per cent), while most did respond to crisis situations (74.4 per cent). Some people were retired, so hours of paid work ranged from 0 to 84 hours per week (mean: 36.54; median: 37.5). When asked about how many hours were worked per week, including paid and non-paid work, this increased to 4–168 h (mean: 55.40; median: 50.75). For respondents who replied to the number of hours of unpaid work with statements such as "all other hours" or "all hours except when I'm sleeping", 74 h were added to the number of paid hours reported, allowing for 6 h sleep per night.

Substance use and predictors

A wide variety of substances were reported as ever used by respondents (see Table III). In a further analysis, past year use is the sum of "past 30 days" and "past year, not past 30 days".

Caffeine and alcohol were the most prevalent substances ever used, followed in the descending order of frequency by pain suppressants, antihistamines, cannabis, Gravol and codeine. The top four were also most frequently reported for the previous 30 days, with the addition of anti-depressants. Some substances were used in the past but not in the year prior to the survey, with tobacco, cannabis and Gravol topping the list, followed by codeine, antihistamines and magic mushrooms.

Few substances that were listed in the survey were inaccurately reported by participants in the category of "other" and each only once or twice (hashish, crack cocaine, steroids, psilocybin,

Table I Province of residence, age range and years of experience

	Number of respondents	*Per cent of respondents*
Province		
Nunavut	0	n/a
Northwest Territories	1	0.2
Yukon	2	0.4
Newfoundland/Labrador	52	10.6
Nova Scotia	30	6.1
Prince Edward Island	1	0.2
New Brunswick	33	6.7
Quebec	1	0.2
Ontario	10	2.0
Manitoba	82	16.8
Saskatchewan	35	7.2
Alberta	199	40.7
British Columbia	43	8.8
Total	489	100
Age range		
19–24	10	2.0
25–29	64	13.1
30–34	67	13.7
35–39	69	14.1
40–44	68	13.9
45–49	38	7.8
50–54	47	9.6
55–59	54	11.0
60–54	37	7.6
65–69	25	5.1
70+	10	2.0
Total	489	100
Years of experience		
< 5	92	18.9
5–9	102	20.9
10–14	75	15.3
15–19	60	12.3
20+	160	32.7
Total	489	100

Notes: $n = 489$, margin of error for a 95% confidence interval (population 18,801) is ±4.37

Table II Specialisation

	Number of respondents	*Per cent of all respondents*	*Per cent of respondents reporting speciality*[a]
Child protection	68	13.9	20.5
Mental health and addictions	114	23.3	34.4
Community (school, employment, disability)	35	7.2	10.6
Geriatrics	22	4.5	6.6
Trauma, domestic violence	22	4.5	6.6
Clinical and medical	40	8.2	12.1
Counselling (including sexuality, family)	30	6.1	9.1
Other or not reported	158	32.5	

Note: [a]Excludes responses of "other" and "no answer"

melatonin, regular Tylenol, codeine). Some substances reported as "other" were not included on the survey (e.g. mephedrone, anti-psychotics, Demerol, dexadrine, dilaudid, PCP, muscle relaxer, salvia X4, nitrous oxide, DMT). Each was only noted once or twice, and these are not included in the statistical analyses.

Table III Past substance use (per cent of respondents)

	Ever	*Past year*	*Past 30 days*
Alcohol[a]	97.1	83.1	71
Caffeine[a]	96.1	92.5	89
Pain suppressants[a]	78.7	56.6	42.1
Antihistamine[a]	75.3	46.4	21.7
Cannabis[a]	68.7	24.1	14.5
Tobacco[a]	65.5	19.8	13.5
Gravol[a]	64.4	19.8	13.5
Codeine[a]	63.2	21	10.4
Anti-depressants[a]	44.8	24.6	21.7
Melatonin[a]	43.1	22.3	10.2
Sleeping medications[a]	42.7	23.7	15.3
Benzodiazepines[a]	38.2	18.4	9.2
Magic mushrooms (psilocybin)[a]	30.3	2.4	0.8
Morphine	21.5	4.7	0.8
Nicotine Replacement Therapy[a]	19.6	5.4	2.7
Cocaine[a]	18.6	4.5	1.2
LSD[a]	17.4	1.6	0.8
Ecstasy[a]	14.3	1.4	0.4
Amphetamines[a]	14.1	4.3	3.1
Oxycodone	13.3	4.1	1.4
MDMA[a]	11.7	2	1
Ritalin	7	1.6	0.8
Barbiturates	6.7	0.8	0.6
Methamphetamine	6.3	0.9	0.5
Solvents	5.7	1.8	1.6
Mescaline	5.3	0.2	0
Alkyl nitrite	4.9	1.8	1
Hydrocodone	4.5	1.8	0.2
Adderall	4.1	1.4	0.8
Fentanyl	3.7	1.6	0.6
GHB	3.3	0.8	0.6
Ketamine	3.1	0.8	0.2
Anabolic steroids	2.5	1	0.4
Heroin	2.5	0.4	0.2
Peyote	1.8	0	0
Buprenorphine	1.6	0.6	0.6
Ayahuasca	1	0.2	0
Methadone	1	0	0
Khat	0.6	0.2	0
Suboxone	0.4	0	0

Note: The substances indicated with "[a]" were used by 10 per cent or more of respondents and are used in subsequent comparison analyses

Analysis of substance use and demographic factors

To explore whether any demographics or work patterns predicted total number of substances used in the past year, multiple linear regression was conducted with the independent variables.

Only years of work experience ($\beta = -0.384$, $t = -4.293$, $p < 0.001$) and working night shift ($\beta = 1.017$, $t = 2.322$, $p = 0.021$) were significant predictors of total number of substances used in the past year. For each additional five-year increment of work experience, the number of substances used in the previous year decreased by an average of 0.384.

Individual substances. To investigate the relationships between the independent variables and past year use of individual substances, binary logistic regression models were fitted separately for each substances whose past year use was reported by 20 or more participants (alcohol, amphetamines, anti-depressants, antihistamines, benzodiazepines, caffeine, cannabis, cocaine, melatonin, nicotine replacement therapy (NRT), codeine, morphine,

oxycodone, pain medications, sleeping medications, tobacco and Gravol). Findings are reported in Table IV.

In the analysis of past year substance use, the model was not significant for alcohol, amphetamine, anti-depressants, antihistamines, caffeine, codeine, cocaine use, morphine, NRT, oxycodone or pain medication.

The model was significant for benzodiazepine use ($p = 0.005$). Work experience emerged as a significant predictor of past year use ($p = 0.002$). As compared to respondents with 20+ years of experience (reference level), the odds of having used benzodiazepines in the past year were more than two times greater for respondents with less than five years of experience, and 3.4 times greater for those with 5–9 or 10–14 years of experience. Those with 15–19 years of work experience reported benzodiazepine use similar to those with 20+ years' work experience.

The model was also significant for past year cannabis use ($p < 0.001$). Work experience emerged as a significant predictor ($p < 0.001$). As compared to those with 20+ years of experience (reference level), the odds of having used cannabis in the past year were more than six times greater for respondents with less than five years of experience, 4.5 times greater for those who had 5–9 years' experience and 2.9 times greater for those with 10–14 years' experience. Respondents with 15–19 years of work experience reported past year cannabis use similar to the reference group.

For the past year melatonin use, the model was also significant ($p = 0.015$). The odds of having used melatonin in the past year were 2.687 times greater for respondents who worked night shift than for those who did not work night shift ($p = 0.001$). As compared to respondents from Alberta, the odds of having used melatonin in the past year were 0.456 times greater for respondents from the Atlantic provinces ($p = 0.014$).

Table IV Binary logistic regression analysis of past year substance use and independent variables

Past year substance use	*Independent variables collectively*	*Province*	*Years of work experience*	*Night shift*	*Crisis response*	*Hours worked per week*	*Total productive (paid and unpaid) hours per week*
Alcohol	$p = 0.193$						
Amphetamines	$p = 0.289$						
Anti-depressants	$p = 0.641$						
Antihistamines	$p = 0.172$						
Benzodiazepines	$p = 0.005$[a]		$p = 0.002$[a]				
Caffeine	$p = 0.310$						
Cannabis	$p < 0.001$[a]		$p < 0.001$[a]				
Cocaine[b]	$p = 0.001$[a]						
Gravol	$p = 0.028$[a]			$p = 0.019$[a]			
Melatonin	$p = 0.015$[a]	$p = 0.038$[a]		$p = 0.001$[a]			
NRT	$p = 0.391$						
Codeine	$p = 0.603$						
Morphine	$p = 0.853$						
Oxycodone	$p = 0.935$						
Pain medications	$p = 0.512$						
Sleeping medications	$p = 0.839$			$p = 0.036$[a]			
Tobacco	$p < 0.001$[a]		$p = 0.008$[a]				
Prescription medications	$p = 0.008$[a]		$p = 0.005$[a]				
Hallucinogens[b]	$p = 0.015$[a]						
Licit substances	$p = 0.351$						
Illicit substances	$p < 0.001$[a]		$p = 0.002$[a]	$p = 0.013$[a]			
Stimulants	$p = 0.461$						
Depressants	$p = 0.420$						

Notes: [a]Indicates significant relationship; [b]indicates the model was significant, but none of the individual predictors were significant

For past year sleeping medication use, the model was not significant but night shift itself was a significant predictor, with the odds of having used sleeping medications in the past year being almost twice as high for those who worked night shift as those who did not ($p = 0.036$).

The model was significant for past year Gravol use ($p = 0.028$), with the odds of having used Gravol in the past year being 2.1 times as great for those working night shift as for those who did not work night shift ($p = 0.019$).

For past year tobacco use, the model was significant ($p < 0.001$) with work experience ($p < 0.001$) emerging as a significant predictor. As compared to those with 20+ years of experience, the odds of having used tobacco in the past year were 2.8 times greater for respondents with less than five years' experience, and 3.1 times greater for those with 5–9 years of experience ($p < 0.005$). Other experience levels reported use similar to the reference group.

Categories of substances. The regression model was tested as a predictor of past year use of categories of substance (listed above). The model was not significant for stimulants, licit substances or depressants. It was significant for past year hallucinogen use ($p = 0.015$), but none of the individual predictors reached significance.

The model was significant for past year prescription medication use ($p = 0.008$), with work experience emerging as a significant predictor. While other groups reported similar use to the reference group, those with 5–9 and 10–14 years' work experience had 1.9 and 2.7 times greater odds, respectively, of reporting prescription drug use in the past year ($p < 0.02$). No other predictors reached statistical significance.

The model was also significant for past year use of illicit substances ($p < 0.001$), with work experience a predictor. The two groups with least work experience had odds 2.5 and 2.1 times greater (respectively) to report illicit substance use ($p < 0.002$); other groups reported patterns of use similar to those in the reference group. Those who worked night shift had odds 2.2 times greater ($p = 0.013$) than those who did not work night shift to report illicit substance use.

Patterns of substance use

To further explore the patterns of use, follow-up questions were asked about each substance a person reported having ever used. Not all respondents who reported using a substance completed the follow-up questions.

Some substances were reported to only have been used once or twice in a lifetime, such as khat, mescaline, methadone, peyote and GHB. This was also true for ecstasy and magic mushrooms, though use three to nine times in a lifetime was somewhat more common. Some substances were reported by almost all respondents as having been used more than ten times in a lifetime, including caffeine, alcohol, tobacco, anti-depressants, buprenorphine, pain suppressants and antihistamines. Frequency of lifetime use for other substances ranged fairly evenly across categories (one to two times, three to nine times, ten+ times). For example, amphetamines, benzodiazepine, cocaine and Ritalin were all reported by about a third of respondents in each category.

Of those who used substances that require a prescription (see Table V), methadone, anti-depressants and opioids were routinely reported as being used as prescribed (100, 96 and 84 per cent). Cannabis was almost always (92 per cent) used without prescription. Benzodiazepine and buprenorphine were typically (~75 per cent) used as prescribed, while Adderall, amphetamines and Ritalin were most commonly used without prescription or in ways not prescribed.

For some substances, respondents were equally likely to report use as a professional as when they were students (Table VI). These tended to be substances used by few respondents (see Table III). Other substances were less likely to be used by respondents when working as professionals, compared to when they were students, particularly opioids, ecstasy, methamphetamine, amphetamine, barbiturates, LSD and magic mushrooms.

In contrast, several substances showed increased likelihood of use when respondents were professionals than when they were students, including most of the substances with greatest reported use. Some substances showed only slight increases, such as cannabis, MDMA,

Table V Substance use as prescribed (per cent of those who reported ever having used)

	I use this substance only as prescribed	*I sometimes use this substance in ways other than prescribed to me*	*This substance is not prescribed to me*
Adderall	23.5	17.7	58.8
Anabolic steroids	57.1		42.9
Amphetamine	22.0	19.5	58.5
Anti-depressant	95.6	1.3	3.1
Antihistamine	48.5	9.1	42.4
Barbiturates	46.1	15.4	38.5
Benzodiazepine	76.1	7.2	16.7
Buprenorphine	75.0		25.0
Cannabis	2.2	5.6	92.2
Opioids (heroin, hydrocodone, morphine, oxycodone, fentanyl)	84.4	4.1	11.5
Methadone	100.0		
Pain suppressants	59.8	6.1	34.1
Ritalin	38.9	11.1	50.0
Sleeping medications	62.7	9.9	27.4
Suboxone	Not reported		
Gravol	37.5	5.2	57.3

Notes: This was a forced answer question. Shaded items can be obtained without prescription

Table VI Correlation between use as student and use as professional

Substance	*Number of times more likely to use, if used as student*
Cocaine	91
Alcohol	47
Pain suppressants	46
Tobacco	37
Caffeine	29
Amphetamines	12
Cannabis	12
Gravol	12
Anti-depressants	10
Sleeping medications	8
NRT	7
Antihistamines	6
Melatonin	4

Note: All correlations significant at $p < 0.001$

alcohol, caffeine and cocaine. Others saw markedly higher rates of use among practicing social workers, including melatonin and sleep aids, anti-depressants and benzodiazepine.

Use of a substance by a person when they were a student was highly correlated with use when they were a professional, as outlined in Table VI. This table indicates the correlation between use of a substance by a person when they are a student and use when they are a professional. Included in this table is an indication of how many times more likely it is that a person reported use of a substance when they are a professional if they used when they were a student, compared to those who did not use as a student.

Discussion

Substance use among Canadian social workers

This population of social workers generally reported high prevalence of substance use compared to the general Canadian population according to the Canadian Tobacco, Alcohol and Drugs Survey

(CTADS) 2015, a telephone survey that included 15,154 respondents (Government of Canada, 2017). The study findings are compared in Table VII. In general, our study participants reported at least double the rates of past year, except for alcohol, which was only 6 per cent higher.

Differences in prevalence might be related to the method of data collection, with our study being an anonymous online survey. There is a possibility of respondent bias in our study, where the deliberate stance of not assuming any use is problematic might have appealed more to individuals who use substances. Alternatively, it is possible that social workers might use more than the general population. There is little anonymous research available about substance use by the general population or other professions in Canada to inform our interpretation of the reported prevalence.

When considering substances that were used at different rates when respondents were professional students compared to rates of use when respondents were professionals, it is important to consider generational, role and historical factors. For instance, barbiturates and LSD were more commonly used when respondents were students than when they were professionals. It may be that a substance like LSD, which is often used for experimentation, is more likely used when people are younger. Barbiturates were more commonly prescribed and used in previous decades, and are likely simply less available today. Since respondents were of diverse ages, there are multiple factors influencing differences. The higher rates of using sleep aids, anti-depressants, and benzodiazepines as professionals might be related to a shift towards using licit substances when working as a regulated professional, increased involvement with medical professionals as one ages, shifting cultural and historical prescribing practices, and increased exposure to stressful life situations.

When examining the prevalence of substance use, it is important to recognise that use is not necessarily indicative of misuse, abuse or addiction. For instance, the Canadian Centre on Substance Use and Addiction reported that while 13 per cent of the population used prescription opioids in the past year, only 2 per cent of that group used for non-medical purposes. Accordingly, findings of prevalence of use should not be conflated with declarations of prevalence of problematic or potentially problematic use. Keeping in mind the variability of social determinants of health that may act as risk factors (e.g. poverty, level of education, access to resources) and protective factors (e.g. stable housing, financial resources, status), it is possible that professionals may experience less detrimental consequences associated with substance use than others who have fewer protective factors.

Findings indicated that use of a substance when a person was a student is correlated with use when they are professionals. Accordingly, it may be worth fostering discussions about substance use early in professional education programs.

Implications for professional regulation

This research has implications for notions of professionalism and for professional regulation.

Table VII Prevalence of past year substance use compared with national report

	Our results (%)	*CTADS results (%)*
Cannabis	24.1	12
Cocaine[a]	4.5	1.2
Ecstasy/MDMA[b]	2.0	0.7
Amphetamines[c]	4.3	0.2
Hallucinogens[d]	2.4	0.6
Opioids[e]	21	13
Alcohol	83.1	77

Notes: [a]Cocaine use reported by our participants. Cocaine or crack in the CTADS study; [b]Ecstasy and MDMA reported by our participants. Ecstasy use in the CTADS study; [c]Amphetamine use reported by our participants. Speed or amphetamines in the CTADS study; [d]Psilocybin (magic mushrooms) reported as most prevalent hallucinogen by our participants. Hallucinogens reported collectively in the CTADS study; [e]Codeine reported as most prevalent opioid pain reliever by our participants. Opioid pain relievers reported collectively in the CTADS study

Within the Canadian context, the relatively high prevalence of cannabis use is timely information with respect to impending legalisation. It is expected that laws for non-prescribed cannabis will be similar to alcohol, once it is legalised (Straszynski, 2016, 9 September). In workplaces, alcohol is treated under the Workplace Drug and Alcohol Policy, which allows employers to restrict use of alcohol during work hours and prohibit working when intoxicated (Straszynski, 2016, 9 September). Prescribed cannabis used in the workplace or during work hours is expected to be treated similar to other prescription medications (Weir and Pennell, 2017). At the same time, professional regulatory bodies claim authority over the off-duty conduct of their members, blurring the boundaries between public and private. The concept of "conduct unbecoming" refers to conduct on the part of a certified professional that is contrary to the public interests, or brings discredit to the profession (Office of the Legislative Counsel and Nova Scotia House of Assembly, 2009). It is often conflated with professional misconduct, mixing together the potential for harm to clients or patients with perceptions of professionally inappropriate or unseemly behaviour. What is considered socially appropriate (or in this case professionally appropriate) is based on predominant social values, norms and beliefs. Professional status carries with it not only expertise and jurisdiction over certain aspects of life, but also social power and authority, a degree of influence. But that authority and influence relies on embodying what has been called "respectability" (Young, 1990, p. 57) – the forms of appearance, speech, tastes, demeanour and comportment deemed respectable. Conduct unbecoming violates those social rules and therefore risks sullying the reputation of the profession, rather than posing specific risk to clients or patients.

The Canadian Human Rights Commission (2017) cautions, "A positive result on a drug or alcohol test may be treated as an indicator of potentially greater risk, but should not be taken as concrete evidence of a substance dependence or that the person has or will, in fact, come to work impaired by drugs or alcohol" (p. 14). Our research suggests there is relatively high prevalence of use of licit, illicit, and prescribed substances that could have the potential to affect performance at work. However, in our research, there are few actual reports of substances having ever negatively impacted work performance as an immediate effect (Kiepek *et al.*, 2018). The relationship between substance use and competent performance of professional roles remains an open question.

Research limitations

Response bias is a potential limitation, as the study may have appealed to individuals who use substances. Studies that explore substance use from non-problematising perspectives may appeal to those interested in increasing social awareness about the prevalence of substance use. However, we did hear from participants with limited experience of substance use and several participants included statements that use of illicit substances was minimal or in the distant past.

Another limitation was in the length of the study, which appeared to lead to some response fatigue. We anticipated this could occur, but since there was little known about the topic of substance use by social workers in Canada and there is a relatively high financial cost associated with advertising in professional organisation, we determined it was important to collect as much data as we could and structured the survey to collect the prevalence data first, which we deemed most novel.

It is likely that reports of alcohol and caffeine had ceiling effects. They were used by virtually all respondents, making it impossible to detect correlations with any demographics or work-related factors. Future research in this area should identify comparisons of interest *a priori* to increase statistical power.

Interpretations of correlational relationships would be enhanced by integrating in-depth qualitative methods to explore how participants interpret patterns of substance use, and changes in those patterns in relation to work-related factors.

Originality

Much of the literature about substance use by professionals is focussed on the implications for increased surveillance, monitoring, and disciplinary action. We contend that professionals have a long history of using substances, but have needed to conceal use (Kiepek and Beagan, 2018), contributing to social misconceptions about degree of risk and uncertainty about when it might be appropriate to intervene.

Our results suggest that the substantial rates of substance use reported, when it is anonymous and safe to do so, highlight the importance of distinguishing between potential for harm and

perceptions of respectability. There are clearly many presumably-competent professionals using a range of psychoactive substances – from coffee to cocaine – that may not in fact be posing risk to public interests. Decisions made by regulatory bodies should transcend social opinion and be based on the best evidence available regarding safe and effective care. At this time, there is very little information about self-reported effects of substance use among professionals and it is essential to extend our understandings.

This paper does not resolve the complex considerations of the appropriateness of substance use by professionals, but it does shed light on the nature of substance use in Canada as changes in legislation regarding cannabis use are in progress. Any decisions made by regulatory bodies should not be reactive to the potential changes in use, without first understanding the current context of substance use by professionals.

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