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CHAPTER 5

PROBLEM DRUG USE IN THE 21ST CENTURY:
A Social Model of Intervention[1]

Julian Buchanan

Introduction

Working with problem drug users can no longer be regarded as a specialist role confined to the domain of drug agencies. Drug use is so widespread that social workers in all fields must now possess reasonable knowledge and skills to engage with this consuming and at times confusing social problem. This is especially important for social workers concerned with health, mental health, child protection, and criminal justice. In the past, help for problem drug users has been left to specialist workers, and too often dominated by a medical model of addiction. Based on 20 years of research and practice with problem drug users in Liverpool, England, the author presents a social model of intervention. Dominant approaches—such as the 12-steps program, the cycle of change, methadone maintenance therapy, in-patient detoxification, and the use of therapeutic communities—all have considerable merit and continue to be used with varying degrees of success for selective groups, but they remain heavily based upon physiological and psychological theory with the emphasis upon individual motivation and personal commitment. The social and cultural changes in the late 20th century, particularly in relation to risk and drug taking, have lessened the impact and effectiveness of these traditional approaches.

In the past two decades a growing hostility has developed, especially in the U.K. and the U.S., toward problem drug users,

resulting in legitimized marginalization and social exclusion. This structural discrimination has become a serious debilitating factor for many problem drug users, hindering their opportunities for recovery. This chapter provides a rehabilitative framework that acknowledges these structural factors, one that promotes social reintegration, anti-discrimination, and traditional social work values. There are generally three types of drug users:

(1) recreational drug users who use illicit drugs in a controlled manner for pleasure without incurring social, psychological, and/or physical problems; (2) dependent drug users who use illicit drugs and have become psychologically and/or physically dependent (this dependence inevitably begins to have some impact upon their social, psychological, and/or physical well-being); and (3) problem drug users who use illicit drugs but have become heavily socially, psychologically, and/or physically dependent; this loss of control will have resulted in significant social, psychological, and/or physical problems; their lifestyle is also likely to pose difficulties for others. This chapter is concerned with this third group of drug users.

Societal Change, Drug Taking, and the Social Context

The last three decades of the 20th century saw significant and rapid social change, nationally and globally, including the widespread use of illicit drugs. Across the Western world experimenting with illicit drugs is now regarded as one of many typical adolescent risk-taking experiences. Standardized school-based survey research in schools in the U.K. found that 50 percent of school children in Scotland and 40 percent in England had tried at least one illicit drug (Parker, Aldridge, Eggington, and Measham 2001, p. 2). In the past, knowledge and understanding of the nature and risk of different illicit drugs among young people was poor. Today, largely through the development of widespread health education programs and mass communication, young people tend to be much better informed.

Choices: Alcohol, Tobacco, or an Illicit Drug?

It is widely accepted that recreational use of cannabis can be relatively unproblematic (Police Foundation 2000), while other drugs, such as heroin and crack cocaine, are more likely to lead to difficulties and dependence. What is interesting is that many young people today make

"risk assessments" when choosing an illicit drug, with cannabis, amyl nitrate, and amphetamine being the most popular in the U.K. (Measham, Aldridge, and Parker 2001). In comparison to the dangers posed by other illicit drugs (and some legal drugs) these choices represent good risk-management decisions. However, there is a tendency to convince young people that all illicit drugs are dangerous and harmful. This stand against drugs inevitably leads to a loss of credibility and trust, which are key factors when trying to assist problem drug users.

In contrast to illicit drugs, alcohol and tobacco use have for many decades been legitimized and heavily promoted as appropriate and acceptable recreational drugs of choice. This dominant cultural perspective (seeing alcohol and tobacco as appropriate drugs for relaxation, socialization, and celebration) is being challenged. Sections of society are making informed risk assessments and selecting different recreational drugs, albeit ones that are currently categorized as illegal. Uncertainty, choice, diversity, and risk are now key themes of postmodern life. In this context it becomes easier to understand illicit drug taking as just one of many life choice options, each involving inherent risks, uncertainties, and benefits. Taking drugs is one of several choices in which there is risk, such as regularly using a mobile phone or eating genetically modified (GM) food.

Risks Created by Illegality

Interestingly, some activities and products in society are deemed "safe," and are promoted until they can be proven dangerous (cigarettes, mobile phones, GM food), whereas illicit drugs are deemed dangerous until research can prove that they are safe. Paradoxically, some of the most dangerous risks arise from the illegal status of the drug rather than from the substance itself. For example:

- using adulterated drugs that may contain rat poison, brick dust, or bleach, which is particularly risky if the drug is injected
- uncertainty regarding the strength of the drugs, risking possible overdose or death
- socializing with a criminal underworld that may lead to exposure to more dangerous illicit drugs and other illegal activity
- administering the drug in secret, in inappropriate and possibly dangerous and dirty places, such as derelict houses, under railway bridges, and isolated places

- being afraid to seek help or advice, fearing stigma and marginalization or even legal action
- engaging in a criminally defined activity, risking a criminal record and possibly imprisonment

Legalization has the potential to remove the vast majority of risk identified above. Ironically, it can be argued that many young people are choosing substances that are, if a clean legal supply could be obtained, far less damaging than the heavily promoted commercial substances of alcohol and tobacco.

Locking up Problem Drug Users: The Enemy Within?

Although the nature and context of drug taking has changed significantly in recent decades, the approach to the problem of illicit drugs has changed little. The war on drugs rhetoric continues. Anyone found choosing an illicit drug risks getting caught up in the criminal justice system. However, as illicit drug use becomes a mainstream activity, drug strategies such as those in the U.S. and the U.K., which lean heavily on the criminal justice system, inevitably create a spiralling prison population. In the war on drugs, drug users are portrayed as a threat and menace to society. Populist politics heighten this fear, then respond by getting tough on drugs. Society then becomes united, waging war against its "suitable enemies" (Christie 1986), and drug users are a convenient group to demonize (Van Ree 1997). This leads to marginalization, isolation, hostility, and distrust toward drug users with the emphasis not on rehabilitation, but on protecting others in society from the dangers of drugs and drug users. Once they are ghettoized, it is extremely difficult for recovering problem drug users to overcome this social barrier of stigma and exclusion. This exclusion must be appreciated and addressed by those seeking to effectively assist problem drug users. The war on drugs is a war on drug users, a civil war against an enemy within (Buchanan and Young 2000).

Case Situation: Mark

Mark is a White, unemployed male aged 22, the eldest of three boys. He was born and brought up in Boot Hill, a densely populated inner city area of Dockside. The area was blighted by high levels of unemployment in the 1980s (65 percent) and never entirely recovered. It also has poor housing stock, serious problem drug use, and high levels of criminal activity. Mark's parents both worked locally at the local factory until it was closed in 1985. Since then his father has been unable to secure permanent employment. His mother works as a cleaner at the local school. His parents separated in 1991 when Mark was just 11 years old. Mark still lives with his mother and two younger brothers, and has regular contact with his father. At the age of 11, like many of his peers, Mark began experimenting with tobacco. At 12 he started experimenting with alcohol, and at 14 he began taking cannabis. This illicit drug brought him into contact with a criminal network and introduced him to other illegal drugs. For the next four years he used cannabis regularly, and occasionally used amphetamine and ecstasy.

At 16, Mark officially left school with no qualifications. He was unhappy at school and actually stopped attending soon after his 15th birthday. He complains that he wasn't suited to school, didn't get along with the teachers, and preferred playing sports and studying practical subjects. His mother thinks he might have dyslexia, though an assessment has never been carried out. After a number of short training courses, Mark was pleased to secure a place as an apprentice plumber just before his 17th birthday. He enjoyed this work, but, sadly, Mark was laid off from his shipyard job just before his 18th birthday due to downsizing. Since then he has remained unemployed and dependent upon state benefits. The only employment he has been able to secure has been illegal, temporary work as a construction worker in a nearby housing development. When he turned 19, Mark began using heroin; within nine months this had escalated out of control, and soon after he acquired a criminal record for shoplifting, handling stolen goods, and theft from a motor vehicle. Mark says heroin gave him something to do each day, which was much better than doing nothing.

Mark's typical day begins with planning ways to generate sufficient income to buy heroin, otherwise he would face unpleasant withdrawal symptoms ("turkeying"). His day usually involves shoplifting from various large stores. Mark prides himself on the skills and techniques he had developed to steal (usually clothes) without getting detected, though shoplifting was a demanding and stressful activity. Mark referred to it as "grafting." Once he has acquired the goods, different skills were needed to barter and sell them quickly, sometimes for ridiculously cheap prices in local streets or pubs. Mark seemed to enjoy the adrenaline rush of stealing and selling. Once he had cash, he said he felt good, as if he'd earned it, but he never saw it as cash, just as a

way to buy heroin. His next task was to find someone who can sell him nice (reasonably pure) heroin. The deal had to be properly managed otherwise he might place himself or the seller at risk of detection. It was also difficult because Mark, by this time, needed a fix and had no way of knowing whether he was buying brick dust or heroin. Once he had heroin in his possession, he needed to get home without being stopped by the police. He could then go to his bedroom, burn the heroin on silver foil, and inhale through a tube and enjoy the euphoric feeling the drug gave him. It was the culmination of a hard day's work and now he could relax and feel good. Each day was the same, a 24/7 treadmill. Not unexpectedly, Mark eventually got caught for some of his crimes, and just before his 21st birthday he was sent to prison for nine months following a burglary. Upon release from prison, he immediately started taking heroin.

A Physiological Approach to Problem Drug Use

Physical intoxication to a drug can be so debilitating that may be difficult for problem drug users to make rational choices until they become drug-free, a situation not uncommon with heavy long-term use of alcohol, heroin, or benzodiazepines. Abstinence-based workers therefore see the removal of all illicit substances from the bloodstream as the only viable option for recovery. Once addicts are detoxed, they become ex-addicts and their status can be regularly and randomly monitored by increasingly more sophisticated drug testing on blood, urine, saliva, or hair. One main abstentionist method is the 12-steps approach, which has its origins in Alcoholics Anonymous (AA), co-founded in the 1930s by Bill Wilson (Hartigan 2001). It emphasizes the importance of admission of wrongdoing, confession, repentance, humility, accountability, and yielding to an unspecified spiritual force (Alcoholics Anonymous 2003). The 12-steps approach has been popular and subsequently spawned a worldwide movement with a range of 12-steps programs to address a variety of personal problems (Bradshaw 1988). While AA concentrates exclusively on alcohol, Narcotics Anonymous (NA) is open to any illicit drug users.

The 12-steps approach is based upon a disease model of addiction in which clients must refer to themselves as alcoholics or drug addicts, even if they haven't taken anything for five years. Recovery can begin only when the client has hit rock bottom, recognizes his or her illness, and then commits to lifelong abstinence. This approach, which regards addiction as a disease for which the person cannot be held responsible, can be particularly appealing. The disease is seen as life-threatening, debilitating, and requiring drastic action. Lifelong abstinence is seen as the only viable option. A strength of this approach is the regular contact, support, and group meetings, which help to keep clients accountable and focused. Recent trends in the U.K. criminal justice system toward urine testing and abstinence orders reinforce abstinence-based models.

Case Study: An Abstentionist Approach

Mark is physically dependent upon drugs. The only way he can regain control of his life is to become and stay drug-free. Being in prison provided him with an ideal opportunity to remove the poisons from his body. Sadly, he went straight back on the heroin when he was released from prison, and will now have to hit rock bottom before he is likely to come to his senses and realize he is an addict who needs help. This relapse illustrates he has no control over his behaviour because he is an addict who is ill. Eventually, he may need to be an in-patient at a hospital detoxification centre followed by a lengthy stay at a residential therapeutic community away from the Boot Hill area. Until then he will behave like an addict, cheat, lie, and steal because he is gripped by a disease that needs treatment.

Limitations of the 12-Steps Approach

The 12-steps approach is suitable only for people who are ready, able, and willing to practise lifelong abstinence and are comfortable with a disease model that pathologizes their addiction and labels them. While it may be successful for those who join, there are many drug users who seek help, but may not be appropriate for the 12-steps model. Alcoholics Anonymous or Narcotics Anonymous are an option for one type of drug user and not the answer for all drug-dependency problems. A wider range of services is necessary for the many other drug users who are at a different stage or who are suited to a different approach. The notion of being cured or sick also tends to leave those that relapse in some difficulty. Once dry or drug-free, a person can feel proud and gain mutual support and affirmation in the group meetings. However, a return to drink or drugs, no matter how small or incidental,

requires admission, repentance, and a renewed commitment to lifelong abstinence. Faced with this stark choice, people who relapse may quickly return to damaging patterns of intoxication.

Emphasis upon Physical Dependence

Abstentionists tend to regard clean legal substitute drugs such as methadone as an unacceptable alternative because the person remains physically dependent, and express concern because methadone is just as addictive as heroin itself (Robson 1999). While this is physiologically accurate, it is potentially misleading because it presents drug dependency as essentially a physical addiction. This has implications for policy and practice. To those who emphasize the physiological nature of dependence, it comes as something of a shock (as many drug users have testified) to discover that the cravings, stomach cramps, and sweats can all come flooding back once people return to the original environment in which they were exposed to the same cues and triggers, regardless of how long they have been away from the environment or how long they have been drug-free.

While the physiological aspect of problem drug use needs to be taken seriously, it is clearly just one component of drug dependence. It does not in itself provide an adequate understanding of dependence, and can lead to the exclusive promotion of abstinence-only programs, suggesting that harm reduction merely condones or prolongs drug taking. However, many problem drug users are able to live normal and healthy lives while maintained on legally prescribed substitute drugs (McDermott 2001), but sadly, access to clean legal drugs is severely limited, and many health suthorities (in the U.K.) are unwilling to provide clean injectable drugs. The preoccupation with physical withdrawal can also lead to a failure to recognize other crucial aspects of dependence. Drucker highlights this point:

> In an environment frightened with powerful moral and legal reactions to the use of drugs, the stigma attached to drugs may come to be a more important factor than the biology of addiction, the demonization of drugs and the criminalization of the drug user (i.e., the war on drugs) could be more damaging to the individual and society than drug use or addiction. (Drucker 2000, p. 31)

Reflection Questions

1. If Mark was physically drug-free in prison, why did he go back to using drugs?
2. To what extent is drug dependency a physiological problem?

Psychological Insights

Realizing that the physiological aspect of dependence is unable to provide a complete understanding of drug dependence, psychologists have usefully identified and introduced various cognitive behavioural theories to help understand drug dependence, including social learning theory, pro-social modelling, and cognitive behavioural therapy. Behaviour can be understood to be a result of behavioural conditioning, combined with the thinking processes. For example, faulty thinking can make unacceptable behaviour more likely to occur. A drug user may think, "I had no choice but to buy a bag of heroin." While factually incorrect, this statement removes choice and personal responsibility. A more accurate and helpful way of thinking would be: "I find it extremely difficult when I have money not to go out and buy heroin."

Motivational Interviewing (Miller and Rollnick 1991) doesn't persuade or manipulate drug users toward particular courses of action; instead, it attempts to empower drug users by assisting them to reflect upon their own situation as they perceive it. It also helps drug users review negative and positive aspects of their lives from their own frames of reference. This process can lead to an inner conflict that may stimulate problem drug users out of ambivalence and into action as they become motivated for change (Buchanan 1991).

The Cycle of Change (Prochaska and DiClemente 1982) recognizes that people who struggle with dependent behaviour tend to be in one of six stages: pre-contemplation, contemplation, action, maintenance, termination, or relapse. Identifying which stage a drug user is at enables a more appropriate response to be offered to the drug user. For example, if a person is at the pre-contemplation stage, then a goal-setting approach is likely to be a waste of time, possibly setting up the drug user to fail. The cycle usefully provides a framework for constructive intervention with problem drug users regardless of which stage they are at.

Case Study: A Psychological Approach

Mark has taken heroin so many times that he does it without thinking because he has developed a learned pattern of behaviour that is triggered by daily events. For example, each time he receives a £5 note, he automatically thinks of buying a bag of heroin. Mark has been assessed as a pre-contemplator. At this stage he is not ready or interested in giving up drugs. If confronted about his drug habit, he is likely to say what others wanted to hear because if he told the truth, people would be reluctant and unable to accept his stated desire to continue using drugs. Enforced detoxification would have no impact on Mark because his dependence is largely psychological, not physical.

Harm Reduction

Physiological and psychological understandings of drug dependence have significantly informed the treatment of U.K. problem drug users, but policy has also been influenced by the pragmatic strategy of "harm reduction" promoted by the U.K. Government Advisory Committee in the late 1980s (Advisory Council on the Misuse of Drugs 1988) and developed in the Netherlands (Buning 1990). This strategy was based on the premise that HIV posed a greater threat than drug use itself, therefore, agencies had to be prepared to accept continued drug use in order to develop relationships with the drug-using community and encourage safer practices to prevent the spread of infection to the non-drug-using population. Controversially, this involved the supply of free, clean needles and syringes, free condoms, and maintenance-prescribing of substitute drugs. Some clinicians even prescribed amphetamine and heroin to dependent drug users, sometimes in injectable form (ampoules). Harm reduction was reluctantly embraced as agencies felt obliged by their responsibility to protect the non-drug-using population from the risk of HIV/AIDS (Riley and O'Hare 2000). However, as the incidence of AIDS cases related to injection drug use began to fall significantly in the mid-1990s across EU countries (European Monitoring Centre for Drugs and Drug Addiction 1999), interestingly so did the prominence and practice of harm reduction. This is not surprising given that the United Nations Office for Drug Control and Crime Prevention (UNDCCP) has not accepted harm reduction. Hartnoll (1998, p. 240) identifies the problem of harm reduction for

countries with a strong abstentionist views: "it lacks commitment to a drug-free goal, accepts or condones continued use of drugs, and implies a hidden agenda of decriminalization or legalization."

Case Study: A Harm-Reduction Approach

Mark has been using heroin for a while. He admits to injecting street heroin and has on occasions injected benzodiazepines. He doesn't share needles as a rule, but has used a needle that a trusted friend had used. He has little motivation to stop taking drugs. To reduce harm, it is best to listen carefully to what he is saying without moralizing or judging him. Mark needs to be shown how to inject more safely, be provided with clean needles, and given information regarding the risks of becoming infected with HIV, and hepatitis B and C in particular. He should be given a prescription for a daily supply of methadone ampoules. This would reduce many health risks and a significant amount of criminal activity. The greatest reduction of harm would be achieved if Mark gave up drugs altogether, but this won't happen (not yet anyway). This strategy is pragmatic, it seeks to reduce harm, maintain contact, and encourage an open and honest dialogue.

Physiological, Psychological, and the Harm-Reduction Approach

U.K. practice with drug users has been shaped by three separate frameworks of understanding: physiological dependence, psychological approaches, and the pragmatic philosophy of harm reduction. While the physiological approach tends to subscribe to pathological notions of dependence promoting ideas of the demon drink or drug, the psychological approaches also run the risk of decontextualizing problem drug users, suggesting that dependence can be controlled largely by internal adjustments in thinking, motivation, or the development of cognitive behavioural techniques. The promotion of harm reduction results in more accessible and appropriate user-friendly services for drug users, but the actual practice of harm reduction has tended to be limited and often confined to narrow health interpretations.

All three frameworks offer an important contribution, but each give limited attention to the social, political, and economic context of drug taking in postmodern society. Many socially excluded problem drug users in the U.K. struggle to break out of a drug-centred existence, even

when they become physically drug-free and demonstrate considerable psychological insight and self-motivation.

Reflection Questions

3. Is being psychologically dependent upon illicit drugs any different from being psychologically dependent upon cigarette smoking? Explain your answer.
4. Can we justify giving Mark methadone ampoules, or is this increasing harm?

Drug Users and Discrimination

The war on drugs rhetoric has demonized, isolated, and discriminated against drug users. The institutionalized use of prejudice, power, and propaganda to promote discriminatory thinking toward people using illicit substances is highly questionable. Many groups such as Black people, gay/lesbian people, transient people, and women, have endured similar experiences and many continue to do so. Many of these discriminatory processes have been challenged and the damaging and offensive stereotypes exposed, though further work is still needed. Sadly, while progress is made to tackle discrimination against one group, new groups emerge, such as drug users, who are subject to personal, cultural, and structural discrimination (Thompson 2001). Like many other discriminated groups, some drug users have internalized the negative and harsh stereotypes imposed upon them, leaving them with poor confidence, low self-esteem, low aspirations, and little self-worth (Buchanan and Young 1996). Social work seeks to combat discrimination in all forms, but the experiences of drug users tend to go largely unnoticed and they are rarely mentioned as a discriminated group. Qualitative research studies (Buchanan and Young 1996, 1998a; Goldson, Kennedy, and Young 1995) involving a total of 200 known problem drug users in Merseyside illustrate how the war on drugs has legitimized and reinforced structural discrimination against drug users, and created a barrier that hinders their capacity to regain control of their drug habit. Common themes emerged from these three studies:

- the social dislocation experienced by problem drug users
- poor experiences of education and employment
- a lack of realistic legitimate opportunities

- separation and isolation from a non-drug-using population
- low self-esteem and a stigmatized identity

Many drug users who seek social reintegration have been unable to achieve it, not because of their inability to become stable or drug-free, but by a "wall of exclusion," a socially constructed barrier that separates problem drug users from mainstream society. Many problem drug users have accepted and internalized discriminatory identities as "smack heads" and feel socially stranded, forgotten, with little hope and few legitimate opportunities (Buchanan 2004). Many regard a drug-centred existence as their only option. It provides an all-consuming alternative, with each and every day involving the same demanding routine. Structural inequality and social exclusion tend to be associated with problematic (not recreational) drug use, and research has indicated that drug use generally is much higher in poor neighbourhoods (Foster 2000). Rarely, though, are these structural factors considered by those working with problem drug users. Treatment agencies are often poorly resourced and waiting lists are common. Helping problem drug users is not high on the political agenda. When problem drug users want to change, many lose heart, feeling trapped within a drug-centred life and wanting help, but seeing few legitimate options available.

Case Study: An Integrated Approach

Mark did well on his methadone maintenance program. He stopped injecting street gear (heroin), stopped sharing needles, used a safer injecting technique, and no longer committed crimes every day to pay for his drugs. His family has noticed a big improvement. Mark talks of wanting a proper job and of being bored sitting in the house watching TV. He is afraid of going out. He feels that people talk about him unkindly, and see him as a thief and a robber, even though he hasn't used any heroin for the past six weeks. While he isn't mixing with people in the drug scene, he is becoming very bored, isolated, and increasingly vulnerable to relapse. The Drug Dependency staff has conducted regular urine tests and are delighted with his progress. They don't see what he is worrying about.

A New Conceptual Framework

Much emphasis has been placed upon tackling the physiological and psychological aspects of drug dependence, and upon promoting health-

based harm reduction. If rehabilitation and reintegration are to become realistic and achievable goals for problem drug users, the social context of drug dependence should be given greater prominence. As discussed earlier, the cycle of change model developed by Prochaska and DiClemente (1982), based originally on helping cigarette smokers give up, has proved effective in helping to understand the distinct stages of dependent behaviour. Significantly the identification of the appropriate stage has enabled drug workers to adopt the most effective and suitable intervention (Barber 1995). With good reason, it has dominated U.K. theory and practice with problem drug users, but it has led to thinking that problem drug use is merely a matter of individual motivation and psychological adjustments. These are important factors, but the social context and structural realities that problem drug users face must also be integrated. The social model below (Table 5.1) integrates the social, psychological, and structural components of drug dependence within a clear framework for recovery. Each of the stages is distinct and problem drug users will tend to work their way down the list. While it is possible to jump back as well as forward between stages, it is extremely difficult for problem drug users to get beyond the wall of exclusion. Some problem drug users may remain at one phase for many years, while others for only a short period.

Table 5.1: Understanding the Stages of the Social Model

1. The Chaotic Stage	Can't see; Don't see; Won't see; Why I should change?
2. The Ambivalent Stage	Sometimes I think I need to do something about drugs
3. The Action Stage	I have decided to make changes; I'm sorting it out now
4. The Control Stage	I have achieved what I wanted to achieve; I'm now stable
The Wall of Exclusion	I feel so put down, intimidated from connecting with the non- drug-using world
5. The Reorientation Stage	With support I am beginning to develop new routines
6. The Reintegration Phase	I am independently developing a new lifestyle and mixing freely in mainstream society

(Buchanan 2004)

Recognizing which stage the problem drug user is in is crucial as it enables a more appropriate response to be made. Accurate assessment

of motivation is often hindered by agency staff's subtle coercive pressure on problem drug users to agree to a particular treatment regime, or to move faster toward recovery. The social model offers an alternative explanation to the long accepted view that problem drug use is a chronically relapsing condition because of the fluctuating motivation of the individual; physiological or psychological dependence; craving or physical addiction. Instead, the social model suggests that relapse is often due to the personal, cultural, and institutional discrimination that isolates and denies many recovered problem drug users the opportunity to socially reintegrate. This creates a ghetto for problem drug users and may lead to social exclusion that keeps them outside of mainstream society.

The Social Model in Practice

Case Situation: Mark

1. *The Chaotic Stage:* Mark did not see that he had a problem with drugs. When he began to achieve some realization, he was unwilling or not prepared to contemplate change. At times he was consumed and dominated by a drug-centred life. At this stage, those close to him tried to offer well-intentioned advice and coercion, but these attempts were usually met with a passive outward acceptance countered by an inward hidden rejection. This led to accusations that Mark could not be trusted and was becoming manipulative, though in reality he was never encouraged to say what he was really motivated toward. It may have been better at this stage to develop an honest and accepting relationship with Mark and avoid moralizing to enable Mark to speak without the fear of rejection. Within this relationship it is possible to offer realistic strategies that may reduce the risk of harm to Mark, his family and the wider community.

2. *The Ambivalent Stage:* During this stage Mark was beginning to consider the negative aspects of drug use, which at times led to a shift in his motivation. Now and again he considered tackling his drug problem. At such times his family and drug workers made concerted efforts to help, believing this was a golden opportunity. Mark valued the attention, acceptance, and support being offered, and obligingly agreed to treatment, but deep down felt coerced. He soon relapsed, which made him feel guilty for letting others down. Arguably, Mark had been set up

to fail because he wasn't ready or committed to sustain such changes. Rather than force decisions, at this stage it would be better to provide Mark with opportunities to explore the pros and cons of his drug use and lifestyle without the family or agency staff projecting their own personal and/or professional views, values, choices, or interpretations. It is important for Mark to begin to openly explore issues from his own perspective, dealing with the competing priorities and values as they may trigger an internal motivation for change.

3. *The Action Stage:* At this stage Mark decides he wants to significantly reduce the harm from taking drugs. He knows that change will not occur overnight, but that it would be a long and gradual process. He wasn't ready to become drug-free, but wanted to stop injecting street gear and eventually give up injecting altogether. His first step was to make arrangements to enable him to obtain clean needles and syringes, and a clean supply of injectable substitute drugs. He knew that he would find it difficult to give up injecting street heroin, so he also began seeing a drug counsellor and talking to his probation officer. Unfortunately, as soon as they discovered he wanted to sort out his life, they pressured him to give up drugs altogether. While this was a positive aim, it was more than Mark could manage, and it caused stress in a relationship in which Mark was looking for support. Too often mistakes are made at this stage by the wrong pace of change. It is important that goals are appropriate, realistic, and manageable.

4. *The Control Stage:* During this stage Mark successfully gave up sharing needles; he stopped taking street heroin, and reduced his use of methadone ampoules from 60 mL to 50 mL of oral methadone. His criminal activity dropped significantly. While this was a real achievement for Mark, it was also a time of change and uncertainty because he was beginning to wonder what to do with his time. The 24/7 lifestyle, which had been so much part of his daily existence, had gone, and Mark was beginning to get bored. He wanted to engage in new activities, but he was extremely apprehensive about the idea of mixing with people who didn't take drugs. He was anxious too about meeting drug acquaintances, worried in case he would suddenly experience cravings or be offered heroin. His moods fluctuated, where one minute he felt vulnerable and the next overconfident. Mark's drug worker explored relapse with him, so that he didn't see it as a major setback but a potential learning experience.

The Wall of Exclusion: A successful transition depended largely upon Mark's ability and opportunities to move away from his drug-centred life and establish alternative routines. This was especially difficult because he had lost his self-confidence when among people who didn't use drugs. He wanted to get fit and thought about joining the local gym, but he felt anxious that people would see him as a smackhead and a thief. The wall of exclusion that social attitudes, government policy, and the media had constructed to exclude drug users like Mark from mainstream society was now hindering his chances of successful recovery. This was a critical period when Mark most needed encouragement from the non-drug-using population if he were to establish a new, alternative pattern of social and economic life, but it seemed to Mark that he wasn't welcome in mainstream society.

5. *The Reorientation Stage:* Three months after Mark had successfully controlled his drug habit, he was complaining of boredom. Although he recognized that he had tackled his drug habit, he hadn't managed to replace his lifestyle dependence, so he was left with a void that was made worse by the sense of exclusion. His drug worker referred him to the Buddying Scheme, and he was appointed a buddy/mentor. His buddy, Pete, had himself been a problem drug user and was acutely aware of what Mark was going through. Pete had a small budget to assist Mark in his reorientation. He met with Mark twice a week, once to engage in a social activity, the other to focus on reviewing Mark's progress and plans. Pete was available anytime by mobile phone to support Mark. Initially Pete and Mark went to a range of mainstream social activities that Mark didn't have the confidence to attend on his own. This included a meal in a pub, 10-pin bowling, going to the gym, and seeing a movie. Eventually, Mark established a routine of social, family, and educational activities that not only kept him busy, but helped him to socialize with the non-drug-using population. Mark was still anxious in case people found out about his past and rejected him.

6. *The Reintegration Stage:* In this final stage Mark makes a complete break from drugs, not just physiologically and psychologically, but socially. For many years Mark has been disconnected from mainstream activities, so normal day-to-day activities, such as engaging in further education, doing voluntary work, enrolling in a vocational adult education course, and applying for a job, were all quite difficult for him. Once he had successfully completed the supported orientation

stage, his confidence and self-esteem grew and he felt more able to participate independently within the social and economical life of the community. Though he is still wary of judgmental attitudes from the non-drug-using population and concerned in case people discovered or referred to his past, Mark has developed resilience and a growing confidence. He is now able to engage actively in mainstream society. Without this purposeful activity and process of social reintegration, the risk of relapse would have been greater for Mark.

Conclusion

Many problem drug users have been disadvantaged and socially excluded prior to taking drugs, and for many the all-consuming drug-centred lifestyle is better understood as an inappropriate solution rather than a problem in itself. There is a tendency to concentrate on the drug problem and see harm reduction and physical and psychological dependence as the key issues. This chapter has argued that the main difficulty facing problem drug users in the 21st century concerns discrimination, isolation, and powerlessness. Social work has traditionally embraced the cause and plight of the vulnerable and the oppressed, and the profession's regard for human rights, empowerment, respect for diversity, respect for the person, fair access to public services, equal treatment, and self-determination (British Association of Social Workers 2002) are particularly important when working with drug users. Further, the enhanced degree and complexity of discrimination needs to be acknowledged when seeking to assist and understand the needs of Black drug users (Sangster, Shiner, Patel, and Sheikh 2002) or women drug users (Klee, Jackson, and Lewis 2002). Social work is ideally placed to articulate and highlight the oppression and discrimination that many drug users experience and to promote a social model to work effectively with problem drug users in a manner that embraces the structural context and seeks holistic solutions that offer them the best opportunity for well-being.

Notes

1. I am indebted to Lee Young for his rigorous analysis and debate, which developed and shaped the thinking behind the social model.

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CHAPTER 6

USING MUSIC TO FACILITATE SOCIAL WORK INTERVENTION

Alex Keen

Introduction: Why Music?

Music evokes some response from everyone, touching each of us at a profound level. By altering timbre, dynamics, tempo, and pitch, music has the ability to bind people together, send them into an emotional trance or aggressively into battle. Music can remove inhibitions, alleviate or induce sadness, arouse feelings of joy and confidence, and unlock creativity and hidden talents. Because music reaches people on emotional, intellectual, and physical levels, it can ease cultural and linguistic barriers while bringing people together in shared experiences. As such, the use of music in social work therapy provides a unique contact and a useful means of intercommunication individually, and in groups and communities.

Using Music in Therapy

Social work academics and practitioners alike are actively committing themselves to ensure that social work remains relevant, efficient, effective, accountable, and, importantly, sensitive to increasingly complex human conditions. Because music is a universal means of communication, it makes sense that professionals working to promote a sense of wholeness, healing, and well-being within individuals, groups, and communities tap into the vast natural resources offered by

Social Work in Health and Mental Health: Issues, Developments, and Actions was created for final year undergraduate and Master's level students in the health and mental health fields. It is primarily a book on social work practice, discussing how one might approach a specific health or mental health related problem or issue as a social worker.

Health and mental health are conceptualized broadly in this volume. The health and well-being of body and mind are seen as integrally connected, shaped by biological, physical, psychological, material, social, and structural features and determinants. Clients are viewed as active, engaged agents, with strengths and resources from which to draw in meeting everyday challenges and major life crises.

Contributions from around the world allow the social work student to learn about current practice in places as diverse as Australia, Finland, China, South Africa, Wales, Canada, and the United States. Each chapter is accompanied by both reflective questions and a case study derived from practice and written to stimulate discussion that develops assessment and treatment planning skills.

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