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10 A Bitter Pill to Swallow: Exploring and Understanding Drug Misuse in the UK

Darren Hill 0000-0002-6713-7496 *and Petra Salisbury* 0000-0002-7499-9510

Abstract

There are few topics that generate as much controversy and evoke such heated dissent than illicit drug use. In grounding the dynamic and the emotive global context, we are going to explore illicit drugs in the UK; to do this the chapter will be broken down into thematic headings, and the reader will be introduced to topics that will explore the social, political, and economic cost of drug misuse in the UK. In writing this chapter, we are taking a critical theoretical position against the individualisation of complex social problems; too often we place the burden of social crises, poverty, and inequality on the shoulders of individuals; it is often a burden to great to bear. The context of drug misuse is framed within this individual discourse globally and locally within the UK; the medical, psychological, and social response overwhelmingly converges on individual responsibility and adjustment; accordingly, our discussion aims to temper that and present a more balanced perspective. We will also look at the response to drug misuse in the UK through policy and legislation, critically examining the shift from harm reduction intervention to promoting recovery. Within the discussion, we will also use the terms drug misuse, drug use, illicit drugs, and psychoactive substances interchangeably. This is a deliberate provocation and intervention on our behalf, and one that hopefully will make you question the shifting reality and perception of drugs and drug misuse; keeping this fluid and contested nature of drug misuse in mind, we would like to introduce you to the next discussion heading.

Prevalence and Magnitude

As discussed earlier, substance use comes in all forms, and it is important we understand the amount of people using illicit drugs. The National Drug Treatment Monitoring System (NDTMS) records the numbers of people who seek treatment for their drug use in **England**. Between April 2020 and January 2021, 31,289 adults sought support for opiate-related treatment and 15,771 also approached services for other 'non-opiate'-related support – not including alcohol (NDTMS, 2021a). For young people, under the age of 18, more general figures are kept in terms of the amount of young people accessing or entering treatment; in January 2021, the total number of young people (under 18) in treatment (year to date) was 8,835 (NDTMS, 2021b).

Box 10.1 Myth: Young People Are Tempted to Try Drugs by Pushers

Whilst there are many drug dealers, most young people are introduced to drugs by a friend or someone they know. Instead of pushing, most people are pulled in by curiosity, social networks, and a desire to experiment.

In **Scotland**, 10,900 adults were in drug treatment in the year 2019/2020, 36% of which was for Heroin-related issues. The statistics for young people were counted in the under 25 age group and showed 1,263 in treatment and 1,742 waiting to access services (Public Health Scotland, 2021).

NHS **Wales** collects their numbers slightly differently, having various age categories above ten years old. Recent data inform that 26,649 people were referred to treatment services, although 9,655 were for alcohol use and the remainder (6,262) were either for 'drug use' or 'not disclosed' (NHS Wales, 2021).

Northern Ireland also includes under 18s in their figures and initially breaks these down into alcohol use (1,397), drug and alcohol use (1,342), and finally drug only (1,525; DoH, 2021). Further breakdowns can be seen on the type of drugs people are using within the documents mentioned above. We must acknowledge that these figures are taken from data sets for structured treatment services and people who are seeking change; these figures do not include those who use drugs and do not seek help.

Research suggests that the number of problem drug users is larger than the official treatment figures, they assert that up to 400,000 people in the UK use opiates or crack in a harmful or problematic way (Hill et al, 2016). Public Health England (2021) also estimated that in 2011 over 87,000 people were injecting drugs raising more questions as to how accurate official statistics are. The Office for National Statistics (ONS) also keeps data for England and Wales regarding the amount of people aged 16–59 who have used 'any drug' in the last year; 'any drug' refers to illegal drugs. The latest data taken from the National Crime Survey (NCS) suggests that over the last year, there has been no change from the previous year in the level of drug use amongst adults and showed that 1 in 11 adults

(9.4%/3.2 million people) had used 'any drug' in the last year. In the 16–24 age group, this figure is higher at 21% or 1.3 million people in this age group. The graph below shows how the figure has changed and in most cases declined, amongst both the 16–59 group and the 16–24 group since 1996. The use in the last month's question was not asked from March 2012 but was reintroduced in March 2015 (Figure 10.1).

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Terminology

When we think about the terms drug use or misuse, we must situate those terms within the broader social, medical, and criminal justice contexts within the UK. Drug use or misuse comes down to intent; a drug user is someone who takes a prescribed or appropriate drug to treat a specific ailment or medical condition. A drug misuser takes a drug to elicit an emotional or physiological effect for pleasure or recreation. There are many illicit drugs and they come in all shapes, forms, and sizes, but generally drugs fall into three overarching categories – depressants, stimulants, and hallucinogens: each having positive and negative implications. It is important to acknowledge here that drug use comes in different forms from recreational to problematic, whatever the form of drug use, drug use or misuse ultimately aims to induce an altered state of consciousness. As we can see from the boxes below, a broad range of effects can be experienced from stimulants, depressants, and hallucinogens (Table 10.1).

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Not all illicit drugs fit neatly into the classification method we have explored, many of them do though. Even the much-hyped emerging **New Psychoactive Substances (NPS)** tend to follow the traditional depressant, stimulant, hallucinogen model; there may be 600 of them currently available but despite the variety they tend to fall within the three major spheres of intoxicating effects explored (EMCDDA, 2020). Despite the number of NPS within the UK, there are several major key drugs that have shaped the illicit drug use landscape: spice, nitrous or nangs, and mephedrone or m-cat (Loi et al., 2015). Synthetic cannabis has become a major drug of choice for many young people and has also found a place within problematic and entrenched drug-using communities, a high proportion of dependent street-based drug users regularly using spice as an alternative to heroin and crack cocaine (EMCDDA, 2017). The use of 'nangs' or nitrous oxide is endemic in inner city areas in the UK, any walk down the road in many parts of the UK will highlight the flotsam of nitrous use, small silver canisters found in most bus shelters and

scattered by many a road kerb sides. Initially, the rise of NPS was attributed to poor-quality heroin, cocaine, and ecstasy. Since the introduction of NPS, the illicit drug world like any market has responded, the quality of traditional illicit drugs such as heroin, cocaine, and ecstasy has improved, and we are at a situation where both the quantity and quality of all illicit drugs have improved.

The system of classification and scheduling for illegal drugs is a controversial one, as it is a convoluted legal process that has evolved from a moral, medical, psychological, and social system. It follows no one logical or coherent process for assessing harm from an objective standpoint. An example of this would be the movement of Class B or C drugs to Class A via their route of administration; if you are injecting a Class B substance, it automatically becomes Class A due to the higher medical risk of the administrative method. The system of classification has also come under attack for not recognising the harm of legal drugs, such as nicotine and alcohol; Professor Peter Nutt in 2009 was forced to resign from his role as Chair of the Advisory Council on the Misuse of Drugs for suggesting that ecstasy was less harmful than alcohol. The system whilst not perfect or unitary in its methodology does provide a regulatory context and represents the evolutionary nature of prohibition and the social construction of drug misuse (Table 10.2).

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The Social Context of Drug Misuse

Drug misuse is a subjective and socially constructed narrative, shaped by a complex system of morality, economics, politics, and legislation. We are not trying to be trite about such a serious issue; quite simply drugs are chemical compounds; they are neutral; they have uses that are practical, medical, and social; it is the meaning that we give to them that create a contested and socially constructed reality (Parssinen, 1983; Young, 1976). The term drug misuse is an emotive subject it conjures up evocative imagery, in both the mind of the individual and the collective imagination of society, resulting in the growth of myth and misconception. Our collective social order and reality often hinge on a narrative that sustains and promotes a battle between good and evil, right, and wrong. The nefarious drug pusher; the degenerate and debased drug fiend; exotic powders, infernal elixirs and mind-altering potions; underpinned by the inescapable torment of the damned in their dependency and enslavement to drugs (Gossop, 2013). As a society, we have created a dualistic moral and mental framework where individuals are separated into

good and bad; deserving, or undeserving, our institutions in the media, arts, and culture reinforces this narrative (Hill et al., 2018). It is a common myth and misconception that drug use, and drug misuse, centres only on poor individual decision-making; the decision to use or misuse drugs takes part in a wider social context. This individualisation of drug misuse forms part of a wider discourse within our society that seeks to isolate and compartmentalise social problems within an individual, rather than looking at wider social determinants that contribute to drug use or misuse. The need to have internal and external enemies to provide a moral framework that separates us into good and bad citizens seems to be a consistent and coherent message of modern western industrial civilisation; as society becomes more complex, so must the tools and systems that manage us and contain behaviour within acceptable parameters (Russell, 2009). Despite the move towards a judicial, moral, and political management of substances with the UK, we must recognise that since the dawn of civilisation individuals, families and communities have required the use of substances to mitigate, manage, and alleviate a range of social, psychological, and physiological needs (Escohotado, 1999). However, in forming a discussion on the social construction of drug misuse, it must be recognised that psychoactive substances form part of a larger family of chemical comforts that operate between the moral dualistic narrative of good and bad. The consumption of psychoactive substances underpins the foundations of society, they provide spiritual connection, meaning, comfort, space for breaks, and relaxation and keep us going at work. A world without psychoactive substances would be a very cold and unfriendly place to work, rest, and play.

The trade in illegal drugs is a global issue estimated to be worth between $400 and $600 billion annually; it outstrips the net worth of the global arms trade and is only beaten by the oil and gas trade in profitability (Hill et al., 2016). The world of illegal drugs follows a sound business model, it has a small number of producers, millions of dedicated and addicted consumers, and relatively small overheads (McKeganey, 2011). The illegal drug industry is flexible and adaptable and responds to the market needs of consumers rapidly. The organisations that facilitate this global trade have links to the international firearms trade, and modern slavery.Even though we have global prohibition, supported by an ongoing ‘war on drugs’, we remain at a stalemate, or some may view a loss and the drugs continue to flow, in increased numbers and of a higher quality.

Drug Misuse: Implications for People – a Psychosocial Perspective

The previous discussion has highlighted the social context of drug misuse; drug use or misuse in the UK sits at a moral crossroads between good and evil and right and wrong, and this moralistic social perspective forms part of our conceptualisation of substance use. Within the UK our response to drug use and misuse has taken a psychosocial turn; the complexity of the issue and the depth of the problem have led to no one response being adequate. A psychosocial perspective takes in medical, psychological, and social factors (these models will be explored later in this chapter; Hill et al., 2016). Within the UK, the psychosocial perspective has converged on a harm reduction response to substance use as both a pragmatic and realistic response to an issue that has no one single solution (McKeganey, 2011).

Box 10.2 Myth: Drug Addiction Is Voluntary Behaviour

One of the popular social myths is that drug addiction is a voluntary decision. A recreational user may begin using drugs in a voluntary way, but over time things can change; recreational use may become dependent use than an addiction. Once a significant habit is formed, addiction changes the way you think and respond to events, and eventually use becomes compulsive and at times uncontrollable.

Before we explore the harm reduction philosophy, it is necessary to explore and situate drug misuse as a multi-factorial activity. Within the UK, the use of substances or illegal drugs has become a 'normal' experience, what was once a 'deviant' outsider activity can now be viewed and experienced as a 'normalised' experience and transitionary encounter for young people in the UK (Parker et al., 1998). We are not making the case that drug use is a given or that misuse and dependency are normal, just that the recreational experience of illicit drugs by young people transitioning into adult life is increasingly behaviour that is not questioned. While this is not the norm, it is perceived as being 'normal' in the lives of young people. Given such a pervasive context, not all illegal drug users engage in problematic or harmful behaviour. Problematic drug use is the use of substances that may be deemed legally or medically unacceptable, dangerous, or harmful (Ghodse, 2010). They may experience legal consequences in the form of arrest, detention, or prosecution for possession, use, or supply of illicit substances from criminal justice services such as the police. There are also social consequences for regular or dependent drug misuse; individuals may experience relationship problems or familial breakdown due to the prioritisation of drug misuse over social relationships. The habitual and consistent use of drugs also comes with economic consequences, illicit drugs are expensive, and habitual use can lead to debts to family, friends, financial institutions, employers, and drug dealers. Many committed drug users also experience both physical and mental health consequences as a result of drug

misuse, and these issues will be explored later. To summarise, substance use becomes problematic when the consequences of use outweigh the positives, whether this be seen from a physical/mental health, legal, social, or financial perspective (Hill et al., 2016).

One of the core features of problematic substance use is the nature of addiction and dependency. Addiction and dependency are used interchangeably, but for the purpose of this chapter, let's set out some terms.

Box 10.3

Polysubstance Use: Polysubstance use refers to the use of multiple substances. Polysubstance dependence or addictions are when an individual uses at least three different classes of substances and does not have a favoured substance that qualifies for dependence on its own.

Dependency is usually attributed to a physical dependence of an illicit drug usually depressants such as opioids or benzodiazepines. Addiction refers to the complex interplay of physical dependency, psychological dependency, and the impact of social factors on long-term and continuous drug use. While it is possible to be dependent on a drug without being addicted to it, more often than not addiction follows dependency.

Recreational drug use can be defined as the use of psychoactive substances to induce a state of relaxation, altered consciousness, heightened perception, or detachment within the mental and emotional state of the user. Recreational drug users of illicit substances tend to use these occasionally and have no regular or continuous issue with the consumption. They use illicit drug to enhance their life and find chemical comfort and relaxation in their recreational experience. As mentioned earlier this relates to an estimated 1 in 11 adults aged 16–59 (ONS, 2021). Advocates of recreational drug users advocate responsible drug use as a method for their consumption and place illegal drugs in the same context as legal drugs such as alcohol, nicotine, and caffeine. Recreational use of illegal drugs, while prohibited, is often socially tolerated and enforced by criminal justice agencies within the UK with a level of discretion.

The Costs and Consequences of Drug Misuse

The Financial Cost

Within this section, we are going to look at the costs of drug misuse moving beyond the individual, to the wider community at large. It is estimated that in the UK, illegal drugs cost society £15.4 billion in policing, health care, and crime (Home Office, 2020). Research conducted by Hay and Gannon (2006) suggests that the number of problem drug users is larger than the official treatment figures; they assert that up to 400,000 people in the UK use opiates or crack in a harmful way. McKeganey (2011) reminds us poignantly that between 60% and 70% of crime in the UK is linked to illegal drugs. The money involved in drug production and supply taints all levels of society from the street to the highest levels of the economic, social, and political world. Economic power buys access at all levels and it would be naive not recognise the influence that the world of illegal drugs has; the money from illicit drugs moves from the shadow economy to the legal economy, through a complex system of laundering and transfer that makes once unaccountable illegal money legitimate. A vast amount of police time at a regional, national, and international levels within the UK is dedicated to this pursuit. The National Crime Agency estimate that up to a £100 billion annually is laundered in the UK, with drugs playing a significant role in that figure (NCA, 2020). The National Economic Crime Centre has a system of reporting suspicious economic activity and reports over 300,000 suspicious activity reports being filed in one year (NCA, 2020a). If the outcome of prohibition and the war on drugs was to reduce the production, supply, and use of illegal drugs, it does not seem to be either effective or making major inroads to the problem. It is estimated that despite a national system of prohibition supported by policing only 5% of illegal drugs, at best, are seized by criminal justice services in the UK.

In counting the costs of drug misuse, we often forget the causation; the economic system we live within supports systemic inequality and nurtures the conditions for illicit drug use; the more unequal we have become the more unhappy, addicted, isolated, and atomised we have become as a society (Wilkinson & Pickett, 2007). It is from this perspective that we see addiction and drug misuse as both a response and a form of self-medication for economic and social inequality. The key to this context is that drug use and misuse do not impact directly on the social, political, and economic elites within the UK. Illicit drugs disproportionately affect individuals who are economically disadvantaged and drawn from working-class communities. The working-class communities that have seen their economic base for survival and existence removed through a process of deindustrialisation and marketisation; have the highest areas of drug addiction and deprivation. The greatest impact of addiction and drug misuse in the UK can be disproportionately found in the former industrial, mining, and manufacturing areas (Parker, 2005). Given this context, it is important to recognise the disproportionate impact of social class within addiction and dependency.

It is estimated that the cost of treating drug addiction and the associated physical health issues cost the NHS up to £500 million a year. Drug misuse and in particular addiction have a systemic impact on the health and wellbeing of the body, and mind; one particular complexity is the link between mental health and addiction. Half of the individuals who are using illicit drugs dependently reported a coexisting mental health problem or 'dual diagnosis' alongside their addiction issues (Hill et al., 2016). Mental health and addiction can be located as 'issues' that are intertwined within wider social and economic factors. However, we must recognise despite social causation the medical model is the dominant model for understanding mental health. The medical-psychiatric-based approach to the identification of substance misuse and mental health has seen the development of two systems that support classification and diagnosis: these systems are the World Health Organization's – *International Classification of Diseases* (ICD 10) and the American Psychiatric Association's – *Diagnostic and Statistical Manual* (DSM-V) (APA, 2013). Within the context of dual diagnosis within this chapter, we are using the DSM-V criteria as in Box 10.4:

Box 10.4

1. An individual who has an identified substance use disorder with a co-existing psychiatric disorder that may be a secondary substance-induced mental health disorder,
2. Or a primary mental health disorder that was present before the use of substances.

Substance Misuse and Mental Health Issues

Within mental health and addiction, the term 'dual diagnosis' is a contested one, there are often passionate organisational and professional discussions over what comes first the problems with addiction or mental health. These discussions are often based on professional and institutional priorities; services are rationalised, organised, and funded by diagnostic labels. Despite medicalisation, there is compelling evidence that mental health and addiction are social and communication issues that are interlinked; this linked complexity is further supported by The Department of Health (2002) guide which describes four possible interlinked relationships (Box 10.5):

Box 10.5

1. A primary psychiatric illness precipitating or leading to substance misuse.
2. Substance use worsening or altering the course of a psychiatric illness.
3. Intoxication and/or substance dependence leading to psychological symptoms.

4. Substance misuse and/or withdrawal leading to psychiatric symptoms or illness.

Despite using a codified manual and having clearly demarked guidance from the Department of Health (2002): it is important to recognise that there is no one single uniform dual diagnosis presentation; it can be argued that there are many different patterns of consumption and multiple and complex presentations of mental distress. One common theme is that mental health, illicit drugs, and addiction are often interlinked and inseparable. Dual diagnosis is at once simple and a thoroughly confusing concept; within a complex world that places extreme pressure on our lived experience, we often experience conflicting mental states of varying degrees (Hill et al., 2016). As individuals seek to alleviate their mental distress, they often seek substances that can be used to medicate psychological and social distress symptoms as a form of self-medication. Often the illicit drugs individuals consume can contribute to or cause mental distress or symptoms often as a side effect. We also live in a society that is built upon economic and social inequality, in such a social context individual are often use illicit drugs to manage complex and traumatic life events, people who have experienced trauma often seek chemical comfort from illicit substances to manage and alleviate distress. The medicalisation of mental health and addiction has supported a narrative and discourse where the fault line for a 'dual diagnosis' is located within the individual. Thus, the impact of poverty and economic inequality on mental health is disguised by a complex layer of assessment, treatment, and diagnosis by medical and allied health professionals, locating the problem as an individual responsibility. In disguising the complexity of causation, it can be argued that the individualised-medicalised system protects those aspects of society that support the economic conditions that contribute to the social reproduction of mental and physical health problems.

Criminal Justice System

The UK criminal justice system, in particular prisons, has seen an increase and acceptance of illegal substances within the prison estate; this increase and normalisation mirror the normalisation of drugs within wider UK society (McKeganey, 2011). The difference we are seeing within UK prisons in the scale and severity of the problem; a wide variety of psychoactive substances are variable, which has led to an increase in difficulty in managing prisoners, as the use of substances creates a culture that nurtures violence through a system of drug debts and retribution. The range of substances available in particular new psychoactive substances such as synthetic cannabis has had a significant impact on the management of prison populations (Duke, 2020). Research highlights that up to 80% of men entering prison between the ages of 17–24 were drug users prior to entering and around 30% continued

to use drug whilst in prison (Liriano & Ramsey, 2003). We discuss this because prisons can be seen as a microcosm of external society; the use and consumption of substances are systemic and endemic and have become somewhat normalised.

Harm Reduction

The promotion of a harm reduction model is an attempt to divert drug users away from criminal activity and problematic, dangerous drug use. Harm reduction also aims to engage people in community drug treatment services either by way of prescription drugs or other harm reduction interventions such as needle exchange services. The adoption of harm reduction as an approach and philosophy is a tacit if not subtle admission that drug use is not going away anytime soon. One of the biggest criticisms of harm reduction is that it acts as a sticking plaster for social, political, and economic conditions that service to sustain addiction; however, Harm reduction interventions are successful in engaging with drug users who fundamentally do not want behaviour change.

Links with Other Social Issues

The complex interplay between poverty, inequality, mental health, and physical health places problematic drug user in a high-risk category for harm and reduced life expectancy. The discourse of drug misuse cannot be viewed as an individualised issue, as we acknowledge in the wider harm reduction movement, drug use and misuse is systemic in its impact on the individual, family, community, and society. The first 50 years of UK drug policy failed to meaningfully recognise the impact of drug misuse on children and young people. The first UK national drug strategy in 1998 “Tackling Drugs to Build a better Britain” explored treatment, prevention, offending, and availability of drugs, but only mentioned children in passing, as an afterthought.

Impact on Children

Hidden Harm (2003) estimated that there were between 250,000 and 350,000 children of problematic drug users in the UK and recommended more coherent joint working practices be put in place to help reduce the impact of parental substance use on children (ACMD, 2003). Since 2008, and with the current UK Drug Strategy, children of drug users and young people are given a central place in the strategy, with specific reignition of the detrimental

impact that illicit drugs have on parenting and outcomes for children and young people.More recently, this recognition of interlinked harm has developed further, with the articulation of the ‘toxic trio’ of drug misuse, domestic violence, and mental health, having a disproportionate impact on the social wellbeing and development of children and young people (Hill et al., 2018). We are not making the case that all parents who use drugs are bad parents. Many drug-using parents function effectively and offer ‘good enough parenting’. The concept of ‘good enough parenting’ combined with the discourse of ‘troubled families’ is a clear indication that this is an area where there are shifting views, complex ethical issues, and uncertain professional practice (Hill et al., 2018). Part of the complexity lies within establishing what ‘good enough parenting’ looks like within any family, let alone drug-using families. Care and love are difficult components to break down; however, good enough parenting can be recognised in the need for parents to place the child’s needs before theirs (Race & O’Keefe, 2017). Parental involvement in problematic drug misuse and drug dependency impacts on their ability to meet the child’s needs over their daily drug-using needs.

The commitment to safeguard and uphold the rights of children combined with the rights of individuals to privacy and a family life is one of the most difficult and complex ethical situations health and welfare professionals face when encountering parental substance misuse. Despite the complexity, a pragmatic path must be chosen for the simple reason that 20% of adults entering drug treatment lived with children and 31% of adults in drug treatment reported that they were parents but were separated from children (McKeganey, 2011). Quantitative research has highlighted that the impact of parental drug use on children has been profound. Children exposed to cocaine in utero have been found to have a higher rate of premature birth, smaller head size, and lower birth weight. The follow-up study of babies exposed to in utero cocaine use has also highlighted suspicious or abnormal neurological signs at birth and deficits in mental and motor development (Lewis et al., 2004). Research undertaken with parents maintained on methadone has highlighted issues, and the use of methadone has a serious impact on neurobehavioral functioning; the effects of methadone were profound and impacted on foetal heart rate and motor activity.Even when we reduce the harm from substance use through treatment and support, there is no such thing as safe drug use, there are only safer alternatives. The impact of drug use and misuse on children and young people is significant . Qualitative studies that have collected the voices and experience of children and young people who have grown up in drug misusing families have highlighted the complex dangers and risks that children and young people face (Barnard, 2007). Many of the children normalised the violence, poverty, and degradation; they recognised that they

were loved but came second place to drugs. The stories highlight lack of food, routines, violence from drug dealers, crippling debts, and most of all the lack of money and material access to the things children needed to not only survive but thrive; this social, psychological, and material degradation was underpinned by a secrecy, as the children of parental drug users are often hidden in veils of secrecy and remain loyal to their parents for fear of removal (Bancroft, 2004). So how do we respond to these complex issues of adult dependency and child welfare, within the UK as we have alluded to previously, we operate a harm minimisation approach to drug treatment, this harm reduction approach is underpinned by a recovery model that sees abstinence as the end goal of treatment but not a prerequisite of accessing support or drug treatment services. This harm reduction model is underpinned by an operational medical, psychological, and social model of practice and their associated theoretical frameworks; we will move on to exploring these frameworks in depth within the next section of the discussion.

Theoretical and Operational Frameworks of Drug Misuse and Addiction

To understand how the UK has responded to problematic drug misuse and recreational drug use, it is important to understand the theoretical models of addiction and dependency. Drug misuse and addiction in the UK is responded to with three overarching theoretical models that of the Medical, Psychological, and Social Model (MPSM). Whilst it is important to recognise that the nature of drug misuse and addiction is contested between these models; we must recognise that the dominant model for managing drug misuse is the medical and psychiatric or psychological model of practice. These dominant systems also shape the social model of practice as they converge on a coherent system of individual adjustment and behaviour modification. Whilst it is difficult to find one overarching theory of addiction, theories that explore addiction and drug misuse can be broadly located at the individual level and the population level. The definitions of addiction vary but analysis by the European Monitoring Centre for Drugs and Drugs Addiction suggests that the key features of addiction involves a repeated powerful motivation to engage in an activity such as drug misuse; addiction is acquired through engaging in the activity; the activity does not involve innate programming because of its survival value; and there is significant potential for unintended harm (West, 2013).

Within the UK, the problematisation of addiction as a fault line within the individual follows a consistent discourse that has been systematic. The discourse of individual responsibility is a primary driving force behind both the

medical, psychological, and social models of intervention. In modelling the individual multiple theoretical positions have emerged; within this chapter, we will situate and explore the key theoretical categories of **automatic processing theories and biological/process of change theories.**

Automatic Process Theories (APT) attempt to explain and contextualise addiction by reference to individuals and their social circumstances. Individuals are regarded as possessing particular personal characteristics or residing in social environments that nurture and sustain addictive behaviour (Hyman et al., 2006). Recovery from addiction for individuals involves behaviour modification or adjustment of individual characterises or social locations. Within APT, the individual learning theories of addiction position addiction as a series of learnt behaviours derived from learning associations between cues, responses, and powerful positive or negative reinforcers (Ahmed, 2011). A key example of APT learning theory is Operant Learning Theory (OLT); OLT is a general theory of behaviour change that is built upon the premise that the presence of cues and the experience of positive and negative reinforcement increase or decrease the likelihood of a certain behaviour (Mook, 1995). OLT is a widely studied and evidence-based learning theory and underpins most models of motivational psychology and behaviour modification. Evidence supporting OLT theories of addiction includes the observation of non-human species acquiring addictive behaviour patterns (Ahmed, 2011).). OLT of addiction has limitations, and it does not account for the importance of self-conscious intentions or beliefs not acquired through experience (Hyman, 2006).

The psychological model of APT has a direct link with the biological/medical model for the theoretical position of **Drive Theory (DT).** DT is built upon the premise that addiction involves the development of powerful drives underpinned by a homeostatic mechanism (Mook, 1995) A key example of DT is the disease model of addiction. It must be recognised that the disease model is vast and goes beyond the scope of DT and has its own unique category of **Biological Theory (BT)**; however, the foundations of the disease model or medical model of addiction rely upon the concept that addiction and drug misuse involve pathological changes in the brain that result in overpowering stimulus to engage in drug misuse and addictive behaviour (Gelkopf et al., 2020).

Underpinning the APT and BT are the **Process of Change Theories (PCT).** PCT form a core intellectual and operational context for addiction services and are a stalwart of behaviour change and modification in addiction theory. PCT focuses on the life cycle of addiction, from initial induction to drug misuse through the development of addiction, the theory looks at and explores attempts at recovery contextualising success and failure as part of an

ongoing and fluid cycle subject to change. PCT focus on not only the cycle of change but also the mechanism, motivations, and desire to change within the individual.

The **Transtheoretical Model (TTM)** is one of the most widely used theoretical models of addiction that underpins policy, practice, counselling, and psychological interventions within addiction services (Prochaska et al., 1992). The stages of change, processes of change, and concepts of self-efficacy and decisional balance are iconic and form part of the core logic, philosophy, and delivery of harm reduction drug addiction services in the UK (DiClemente et al., 1991). While the TTM is located at an individual level of adjustment, its theoretical operational within the processes of change recognises the importance of the social and population level of addiction. It is with this in mind that we move on to social or societal level theories of addiction (Figure 10.2).

<COMP: Place Figure 10.2 Here>

With social theories of addiction or population modelling, there are a range of addiction theories; there are those that focus on social networks, behavioural economics, and models of communication and those that explore populations as systems. Within this discussion, we are going to focus on Social Network Theories (SNT); SNT highlight that the rates of transition into and out of addiction on the part of individuals within a group are a function and expression of the social connections between them (Valente et al, 2003). Addictive behaviours can occur in multiple levels within a social context, through families, local area groups, subcultures, and ultimately large-scale populations.

Key examples of SNT include diffusion theory which explores non-linear diffusion of innovations in illicit drugs; new psychoactive substances would be a good example of this (Ferrence, 2001). Social Contagion Theory focuses on connections between individuals and groups to chart uptake and cessation of addictive behaviours.Within the UK, the concept of individual and social models of addiction theory fit into an operational delivery context that combines both individual and social theories of addiction. Our services are contracted with medical, psychological, and social models of addiction and the interventions are undertaken at a community context. With this operational context in mind, we now move on to our next section exploring policy, practice, and the complex discourse that surrounds drug misuse in the UK.

UK Drug Policy and Legislation: From Free Trade to Prohibition

Historical Overview

The UK has had an ambivalent position with drugs and psychoactive substances; we have moved from a position of free trade to prohibition. This shift in social attitudes, policy, and legislation has been informed by three central discourses: the moral; the medical, and the criminal. Historically the UK and the Crown, through its operational arm the British East India Company (BEIC) were part of one of the first and largest international drug cartels openly and legally trading in opium and other psychoactive substances (Parssinen, 1983). British India, or to be more concise the BEIC had been the largest supplier of opium to China. It is ironic given our contemporary position of prohibition that the UK with the BEIC as a protagonist, fought several wars against China, who had tried to prohibit opium importation and smuggling. It is estimated that up to 10% of the population of China was dependent on opium during this period.We must also recognise that the process of industrialisation and urbanisation during the 18th and 19th centuries was both chaotic and unstructured; there was no national health service and narcotics provided both medical and social relief to the brutal living and working conditions of the poor and working classes. Marx remarked religion was the opium of the masses, but in truth, opium was the opium of the masses (Gossop, 2013). The sale and consumption of substances was unregulated until the mid-19th centuries when we see the rise of medicine as a professional institution. The eventual shift in attitudes towards international opium dealing came from a diminishing return on revenues and the development of a significant and vocal anti-opium lobby within the UK.

This use of moral, medical, and criminal justice narratives to shape the response to narcotics within the UK becomes part of a systemic tool for control and regulation and a consistent theme to this day. The late 19th, early 20th century sees a shift in attitudes towards the regulation and control of narcotics. The legal disciplinary capture of psychoactive substances from over-the-counter panacea for social distress and medical complaints to control by the state announces the end of an era of the comfort-given substance. The first regulation of psychoactive substances develops from a moral panic around the opium-addicted urban poor, a familiar often repeated narrative in the UK. The Public Health Act 1848 and the Pharmacy Act 1868 attempt to manage the distribution of psychoactive substances through the newly emerging medical profession. This national context was developed further by the first international drugs legislation that was enshrined in 1912 at The International Opium Convention at the Hague; the convention was signed by 12 nations including the UK. This global convention reinforced the position that the distribution of opium should be regulated by the medical profession and non-medical use was to be criminalised. The early 20th century was characterised by global conflict (World War I) and economic collapse during the great depression. Within this context of conflict and turmoil, psychoactive substances were characterised as external and

foreign threats with the Regulation 40B of the Defence of the Realm Act 1914 (DORA) followed up by the Dangerous Drugs Act 1920. The legislation provided both a criminal justice context and medical role for the distribution of drugs. Throughout this period, we see the development of a deeper codification of the criminal justice and medical context of regulation and control. The Departmental Commission on Morphine and Heroin Addiction 1924–1926 or the Rolleston Report as it was headed up by Sir Humphrey Rolleston confirmed that addiction was a disease and that it should be treated by medical professionals. This report enshrined medicine as the gate keepers for addiction, its treatment, and the provision of drugs as medicines; it began a comprehensive system of treatment known as the 'British System'. The mid-20th century to the early 21st century sees another shift in the legislative and policy context; the medical discourse becomes reduced as a greater emphasis on criminal justice becomes central in the management and control of drugs and drug treatment.

Contemporary Policies

The mid to late 20th century sees a systemic shift in how health, education, justice, and broader welfare services are delivered. The creation of the NHS and the development of psychiatry as an established specialism of medicine created a radical overhaul in the provision and regulation of illicit drugs and drug dependency. Sir Russell Brain chaired the Interdepartmental Committee on Drug Addiction in 1961 and 1965, respectively, the two reports by this committee recommended the shift in treatment from general medicine; general medicine was described as facilitating addiction by creating dependency. Treatment was to be moved to the more specialised psychiatric and in patient community services; we see the beginning of addiction and mental health as a dominant discourse. During this period, drug treatment is moved in from general medical practice in the community to the special hospital and psychiatric clinic; general practitioners are placed at the centre of a moral panic where they are painted as encouraging and sustaining drug use. This policy and practice shift is also mirrored in legislation with the Dangerous Drugs Act 1967 (DDA 1967) and the Misuse of Drugs Act 1971 (MDA 1971). The MDA 1971 set clear parameters for criminal justice measures and in principle the schedules of classification and penalties reflected the potential for harm. Three classes were established (A, B, C) and drugs were allocated to them on a set criterion: whether they were being misused; whether they were likely to be misused; whether the misuse was likely in both previous cases to have or could have harmful effects sufficient to constitute a problem. The Misuse of Drugs Act 1971 has provided the foundation for all subsequent responses to illegal drugs, their prohibition, and treatment in the

UK. The context for this legislation is the principle of harmfulness; however, the principle of harmfulness is not clearly established and is a hybrid of medical; social, moral, and legal models of practice. The notion of harmfulness can be considered as paternalistic and has no clear established evidence base. The MDA 1971 is based more on a model of socio-moral objection rather than an empirical approach to harm or its reduction. Despite criticism, this system of classification has become entrenched as the foundation of our criminal justice response. This system remained firmly in place until the Psycho Active Substances Act 2016 which was developed in response to the mass production and development of hundreds of new psychoactive substances that the legislative framework of classification could not keep up with. The Psycho Active Substances Act 2016 still maintains the classification and schedule system for enforcement and has evolved to meet todays saturated drug market. Highlighting the agility and flexibility in the legislative response, rather than focusing on individual substances it makes all psychoactive substances subject to a criminal justice context. The late 20th and early 21st century sees not only a greater range of criminal justice response to drugs but also a shift in drug policy, and drug treatment from the specialist medical psychiatric model to a more criminal justice framework. There is a tacit acceptance that prohibition has failed in that interdiction and enforcement are tenuous. With this recognition of the failure of interdiction, the criminal justice and medical models converge upon an expanded harm reduction model of treatment; this shift is implemented through a series of UK Drug Strategies (1985, 1998, 2008, 2010, 2017; Table 10.3).

<COMP: Place Table 10.3 Here>

UK drug policy has flip-flopped between whether it should punish, educate, or treat its drug users and without any real success has, over time, attempted all three. Whilst the reduction of drug-related harm and good evidence-based treatment and support is welcomed and needed; harm reduction does not address the wider issues that nurture, support, and facilitate drug addiction and dependency.

Summary

The use and misuse of substances in the UK is an issue that is here to stay; drugs and illicit substances are part of our social, political, and economic fabric of our society. Given the harm caused by illicit drugs and the discussion highlighted within this chapter, the only pragmatic conclusion would be to argue for drug legalisation. We can see the compelling evidence for this, much of the harm associated with drug misuse is rooted in the policies, legislation,

and criminalisation of drug use. However, tempting this proposal is we must ask ourselves this: if we legalised all drugs would addiction and dependency levels remain stable and manageable levels? It is difficult to predict the future but given the prevailing economic and social conditions of systemic inequality, we have seen drug addiction and dependency increase as society has become more fractured and individualised. The issue of drug-related harm cannot be addressed by removing barriers to access or promoting behavioural models of intervention. A more developed harm reduction model must have truly political dimension that seeks to address the social determinants of addiction at a legislative and policy level. Illicit drugs and dependency can only be minimised when people have increased access to better social and material resources, improved living conditions, and increased community cohesion. Drug dependency is underpinned by isolation, inequality, and low status in the social odder of society; to beat isolation, anxiety, and addiction, we need social solidarity and economic equity as a foundation for a good society.

Points to Ponder

Should illicit drug be legalised in the UK?

If we legalised all drugs would addiction and dependency levels remain stable and manageable levels?

What would happen to the drugs trade if drugs were to be legalised?

Reflective Point

Reflecting on the schedule of classification (A, B, C) developed in the UK to manage drug misuse.

If you had to develop a criminal justice system to manage drug misuse how would you do this?

How would you measure harm?

What system would you use, moral, medical, social, or psychological?

Quiz

State whether the following items are True or False

1. Allowing people to use drugs in your home is a crime?

2. Cannabis (weed) can only be smoked?

3. Using Cocaine can lead to weight loss?

4. Nitrous oxide is a harmless drug?

Choose the Correct Answer:

5. Amphetamines are:

   a. Depressants b. Stimulants c. Hallucinogens

6. Is Heroin a

   a. Stimulant b. Depressant c. Hallucinogen

7. Magic Mushrooms are a

   a. Stimulant b. Depressant c. Hallucinogen

Fill in the Blank in the Following Items

8. _______ is a highly addictive form of cocaine processed into a crystal.

9. ________is the most common mind-altering substance used during adolescence.

10. ________is a synthetic drug with stimulant and hallucinogenic effects.

Answers

1.True. 2.False. 3.True. 4.False. 5. Stimulant 6. Depressant. 7. Hallucinogen

8. Crack 9. Marijuana 10. Ecstasy

Small Group Discussion

Activity One

Please consider the following drugs detailed below.

What category do they belong to, are they a depressant stimulant or hallucinogen?

Cocaine, Heroin, Magic Mushrooms, Amphetamine, Ecstasy, Spice, Ketamine.

Do these drugs fit into one category?

Which of the drugs would you consider a recreational drug and which drug would you view as causing dependency?

Activity Two

Each student is to take the name of a drug, and the students must decide upon themselves the order of harm for each drug. Students must make a line from least harmful to most harmful and discuss why they have done this.

More information regarding this activity can be found by reading Chapter three Nutt, D. 2012. Drugs Without the Hot Air. UIT, Cambridge.

Figure 10.1 Drug misuse in England and Wales: year ending March 2020 (ONS, 2021)

Figure 10.2 The stages of change (Prochaska & DiClemente, 1983)

Table 10.1 Positive and negative factors of stimulants, depressants, and hallucinogens

Stimulants: This group includes cocaine, crack cocaine, meth amphetamine, mephedrone, and amphetamine.
Positive Factors (Short Term): These drugs speed up the central nervous system and produce feelings of confidence and energy. People often feel the best they have ever felt (euphoria) and experience increased social functioning including talkativeness, confidence-increased humour, and empathy. They also reduce appetite and tiredness.
Negative Factors (Long Term): Stimulants can lead to cardiovascular issues and result in fatal heart problems and strokes. Hyper-active social presentation, self-reinforcing behaviour (tapping, rocking), anxiety. Withdrawal from stimulants can leave users restless, irritable, sleepless, and paranoid, anxious, and with suicidal thoughts.
Depressants: This group includes opioids, alcohol, and benzodiazepines.
Positive Factors (Short Term): These drugs can slow the central nervous system down and produce feelings of relaxation, euphoria, and general well-being. They can make the user feel warm, protected, and worry free and relieve anxiety and tension.
Negative Factors (Long Term): Social detachment, anxiety during withdrawal or detoxification. Risk issues with polysubstance misuse (alcohol–opiates–benzodiazepines) overdose and death may occur. Depressants often slow down reactions: hazards and accidents are more likely to occur in social contents. A physical dependency (recognised by medicine) that has an acute withdrawal when they are taken over extended period in large amounts, the dependency can impact on social functioning and presentation within society
Hallucinogens: This group includes LSD, magic mushrooms, and cannabis.

Positive Factors (Short Term): Hallucinogens give a heightened appreciation of the sensory experience and perceptual distortion: essentially hallucinogens are taken to induce a psychotic state.
Negative Factors (Long Term): Negative experiences can occur on hallucinogens the experience is directly related to users' mental and emotional state**.**

Table 10.2 Legal classification of various drugs in the UK

Legal Classification	**Drugs**	**Possession**	**Supply/Production**
Class A	Heroin, Cocaine, Crack Cocaine, MDMA, Ecstasy, LSD, Magic Mushrooms, Amphetamine (prepared for injection)	Up to 7 years in prison, an unlimited fine or both	Life in prison, an unlimited fine or both
Class B	Amphetamine, Cannabis, Barbiturates, Codeine, Ketamine, Synthetic Cannabinoids, Synthetic Cathinones (mephedrone)	Up to 5 years in prison, an unlimited fine or both	Up to 14 years in prison, an unlimited fine or both
Class C	Anabolic steroids, benzodiazepines (diazepam), gamma hydroxybutyrate (GHB), gamma-butyrolactone (GBL), piperazines (BZP), khat	Up to 2 years in prison, an unlimited fine or both (except anabolic steroids - it's not an offence to possess them for personal use)	Up to 14 years in prison, an unlimited fine or both
Temporary Class Drugs	Some methylphenidate substances (ethylphenidate, 3,4-dichloromethylphenidate (3,4-DCMP), methylnaphthidate (HDMP-28),	None, but police can take away a suspected temporary class drug	Up to 14 years in prison, an unlimited fine or both

	isopropylphenidate (IPP or IPPD), 4-methylmethylphenidate, ethylnaphthidate, propylphenidate) and their simple derivatives		

Table 10.3 Drug strategies in the UK

Drug Strategy Name	Year	Key Points
Tackling Drugs to Build a Better Britain	1998	• Help young PEOPLE to resist use. • Protect communities from drug-related anti-social behaviour. • Treatment – enable people to seek help to live drug/crime-free lives. • Availability – stifle availability on our streets
UK Drug Strategy	2010	• Reducing demand • Restricting supply • Building recovery
UK Drug Strategy	2017	• Reducing demand • Restricting supply • Building recovery • Global Action

Supplementary Reading

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Service user organisations working in the topic area

Adfam (Information and support for the families of drug and alcohol users): https://adfam.org.uk

Frank (General information, advice and support): https://www.talktofrank.com/

Narcotics Anonymous (12 Step Recovery Group): https://ukna.org/

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