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A Social History of Problematic Substance Use

Social workers require knowledge and understanding of the socio-political and historical context of the issues with which they work. In order to understand why we meet with individuals, families, groups and/or communities we must understand not only their personal stories but the context and nature of the issues that they bring. In this way then it is important for social workers to understand some of the history of substances, their use and the political and socio-cultural factors that led to their prohibition or strict regulation. It is important to understand this history as it helps to explain why users of substances are often portrayed negatively, and why people who may have problematic substance use are marginalised and criminalised. To truly understand the nature of the problem or perceived problem provides an anti-oppressive footing, which should be at the heart of all social work practice.

The normalisation of substance use

‘Attempts to govern morals pervade the history of human societies’ (Rimke and Hunt, 2002: 60). Around the world society’s attempt to govern the use of substances has been profound, but it has not always been this way. Substance use for many centuries was seen as a religious experience, as providing creative inspiration, self-medication and/or recreation, with little or no moral condemnation or social control (Bennett and Holloway, 2005). Medicinal use of cannabis in China and the chewing of coca leaves for energy and strength in South America have been documented as dating back several thousand years (Bennett and Holloway, 2005). Throughout history, the use of alcohol, cocaine and opium was unexceptional among people of all classes and backgrounds, including great poets, writers, artists and medical professionals and until the 1960s most known ‘addicts’ in Britain were ‘professionals’ (doctors, dentists and pharmacists) who had direct access to morphine and other substances (Bennett and Holloway, 2005; Davenport-Hines, 2004). In the eighteenth and first half of the nineteenth century, Britain had a well-established lay and commercial opium trade primarily

with Turkey and imported stocks of opium and associated paraphernalia, that was distributed throughout pharmacies and grocers around the country (Strang and Gossop, 2005). Alcohol has played and continues to play an important role in many civilisations around the world (Lloyd, 2010). Britain in particular has a long proud history of making ales and beer and over the course of history alcohol use and indeed drunkenness among all classes has not been uncommon.

The use of substances throughout history was normal, and there was very little if any moral judgement of it. It was only later that health and social concerns leading to medicalisation and then a criminalisation of substance use transpired.

Health and social concerns

In London in the early to late 1700s, the concern regarding drinking, and specifically drinking gin, became known as the 'gin epidemic'. Gin was known as 'mother's ruin' and the 'demon drink' and was blamed for social unrest and absenteeism among the working classes. It is argued by some, however, that in reality gin was merely a concomitant factor in these issues alongside overcrowding and poverty (Abel, 2001). Health concerns regarding alcohol use were officially published by American Benjamin Rush in 1790, when he released *An Inquiry into the Effects of Spirituous Liquors on the Human Body and the Mind*, more commonly known as the 'Moral Thermometer'. The thermometer provided a visual depiction of the 'horrors' of drunkenness and was later used to support the temperance movement.

Concerns about other substances were also raised when health and social problems relating to their use also started to surface. Alongside public drunkenness and absenteeism, accidental overdosing was quite common. Had it not been for the fact that these health and social problems began to impact on economic productivity, the 'ruling classes' may not have cared about the impact substance use was having on the working classes. Abel (2001) argues that the ruling classes strongly endorsed 'poverty theory' at this time, the premise of this theory being that the working classes needed to be paid little and kept in poverty so that exports remained competitive. This also kept commodities out of their reach, which in turn meant that they had to work hard to survive, which further supported the continuation of the class system.

In line with poverty theory and over concern about decreased productivity, the 'ruling classes' argued that substances and those who used them needed controlling; that individual conduct should be governed in the interests of the nation (Rimke and Hunt, 2002). So began the inextricable link between the use of substances and wider social and cultural concerns and a campaign that would eventually see many substances prohibited or highly regulated (Mold, 2007):

The respectable classes experienced deep apprehensions about the declining hegemony of the traditional authority of the social, political and religious establishments. They responded with a disparate array of projects of moral regulation. (Rimke and Hunt, 2002: 66)

The medicalisation of substance use

Following Benjamin Rush's earlier work on the 'moral thermometer' and during the last quarter of the nineteenth century, the medical profession was beginning to theorise about substance use, associated health problems and 'addiction'. The term 'addiction' first emerged in the nineteenth century as an explanation for the overwhelming desire to use alcohol (Mold, 2007). While addiction was initially seen as a disease caused by the consumption of alcohol, the concept soon began to be located in the 'alcoholic' rather than the alcohol itself (Mold, 2007). An alliance in the form of the 'social and moral hygiene' movement soon formed from the moral codes rooted in religious views and that of the 'new' medical institution (Rimke and Hunt, 2002: 61). Medical professionals began to refer to 'addiction' as a moral pathology, which saw those who were 'addicted' as having an 'impaired moral faculty' (Mold, 2007: 2). 'History can provide numerous examples of how the application of scientific knowledge to a "problem" such as drug use is not value free: but socially and culturally shaped' (Mold, 2007: 6).

So, while the use of substances began to be prohibited and restricted due to the real and perceived health and social problems they created, the users of the substances themselves also began to be vilified. The association between the use of substances, immorality and disease had begun.

Towards the end of the nineteenth century, doctors favoured a combination of medical treatment and 'moral enlightenment' in order to treat the 'disease' of 'addiction', and the medical profession had control over this treatment (Bennett and Holloway, 2005). The 1920 Dangerous Drugs Act permitted doctors to prescribe 'dangerous' drugs even to known 'addicts' if it was deemed medically necessary. This medical approach is often called the 'British System' and was unique to Britain at a time when America was demanding complete prohibition around the world. The 'British System' evolved with the publication of the *Rolleston Committee Report* in 1926. This report supported the continuation of this prescribing strategy, reaffirming the 'disease' model of 'addiction' and placing the responsibility for the treatment of 'addiction' with medical professionals (Bennett and Holloway, 2005; Strang and Gossop, 2005). It was argued that this decision to 'medicalise' the problem rather than 'criminalise' it at this stage, which was different to other countries (including America), was due to the fact that Britain had at this time in reality only a small problem with the use of drugs (Bennett and Holloway, 2005).

The criminalisation of drug use

While the medical profession was still the dominant force in the treatment of 'addiction', in the early 1900s the British government began to take more of an interest in 'drug addiction'. It was at this time that thinking about the criminalisation of substance users began. For the same reasons that drug use was medicalised, drug users slowly began to be criminalised.

Opium use amongst the working class was thought to be damaging to morality and detrimental to production, echoing elements of the temperance movement's attack on alcohol. (Mold, 2007: 3)

The Opium Convention, signed by 12 nations at The Hague in 1912, proposed among other things the closing down of opium dens and that the possession and sale of opiates (morphine, opium and heroin) to unauthorised persons should be punishable by law (Bennett and Holloway, 2005). Following the signing of the Opium Convention, the British Home Office began to take responsibility for matters relating to dangerous drugs (in June 1916). This included a focus on international distribution and consumption.

The Dangerous Drugs Act of 1920, while placing the prescribing of drugs in the hands of the doctors, prohibited the importation of raw opium, morphine and cocaine, and allowed the Home Office to regulate the manufacturing, sale and distribution of dangerous drugs (Bennett and Holloway, 2005). This appeared to mark the beginning of the criminalisation of drug use in Britain, and ratified the principles of an even earlier Defence of Realm regulation that came into force in 1915, that was concerned with the use of drugs by the British armed forces in the First World War. Britain made cannabis illegal in 1928 as it had been previously omitted from the Dangerous Drugs Act.

Following the introduction of these policies, substance use and the number of known 'addicts' remained relatively low and constant in Britain until the 1960s. The 1960s, however, saw a marked increase in the use of drugs by a wide range of people from all social backgrounds. This increase in the use of what were now 'illegal' substances appears to have come about due to younger people having more personal income, more movement of people and substances around the world and the sixties culture encompassing 'freedom' and the importance of spiritual experiences. The use of heroin registered the biggest rise at this time, but cannabis and cocaine were also regularly used, especially in London's 'music scene'. At this time, some of the powers that medical professionals had enjoyed under the 'British System' began to be limited by the Home Office. It was thought at the time that the marked increase in drug use that was being seen was as a result of over-prescribing by a small number of doctors. Following this 'explosion' in the use of substances, there was a perceived need to regulate further and criminalise the use of drugs.

Drug policy and legislation

The 1960s

The Interdepartmental Committee on Drug Addiction, chaired by Sir Russell Brain (the *First Brain Report*), reinforced the findings of the earlier 1926 *Rolleston Report* and favoured the continued use of drug prescription for 'addicts' where necessary, and emphasised the relatively minor scale of drug use in the UK. While this report was widely criticised at the time for not recognising the changing drug-using culture in the UK, the media had begun to pick up on

these changes. It was at this time that sensationalist reporting of the dangers of the 'drug epidemic' began.

The 1961 UN drugs convention, the Single Convention on Narcotic Drugs, marked a key turning point in global prohibition, safeguarding prohibition in domestic law around the world, and closing down any possibility of regulated models of the production and supply of illicit drugs (paradoxically, alcohol and tobacco were excluded) being introduced by individual countries. The Brain Committee was reconvened in 1964 following pressure from the media and the public. While this report (the *Second Brain Report*) was more realistic, it is said to have focused too narrowly on the London scene and neglected other parts of the UK, where drug use culture was also changing (Yates, 2002).

The UN Drugs Convention and the *Second Brain Report* informed the implementation of the Dangerous Drugs Act 1967, which effectively saw the beginning of the end of the 'British System' of opiate prescribing. The Dangerous Drugs Act introduced the notification of 'addicts', wide-ranging restrictions on the prescribing rights of doctors, and the establishment of special treatment centres or clinics for the provision of drug treatment (Drug Dependency Units or DDUs). The right to prescribe heroin and cocaine to 'addicts' was now limited to specialist psychiatrists working in these clinics and equipped with a licence from the Home Office (Lart, 2006). The quantity of these drugs that was prescribed was also dramatically reduced, with the heroin substitute methadone often being supplied in their place (Transform Drug Policy Foundation, 2009). The limitations placed on the prescribing of opiates and cocaine by the Dangerous Drugs Act 1967 came at a time when the black market for drugs was becoming established, especially in London. Whether or not this new legislation caused the black market, or was in response to the beginnings of it, is arguable, but what was clear was that the number of drug users continued to increase through the 1960s and well into the 1970s (Yates, 2002).

The Misuse of Drugs Act 1971

The 1971 Misuse of Drugs Act 1971 established the Advisory Council on the Misuse of Drugs (ACMD). ACMD was set up to advise the government about drug misuse prevention, and how to deal with social problems related to drug misuse (Yates, 2002). The Misuse of Drugs Act also implemented the 'schedule' system in accordance with the judgement of the UN Commission on Narcotic Drugs as to the potential for abuse and the therapeutic value of each drug. These schedules govern possession and supply of drugs controlled under the Misuse of Drugs Act as well as prescribing, safe custody, importation, exportation, production and record keeping. These criteria still underpin UK drug policy today. Under the Misuse of Drugs Act it is an offence to possess a controlled substance unlawfully; possess a controlled substance with intent to supply it; supply or offer to supply a controlled drug (even if it is given away for free); or allow a house, flat or office to be used by people taking drugs.

Table 1.1 Drug classification under the Misuse of Drugs Act 1971

	Drugs (including but not limited to)	Penalty for possession	Penalty for dealing/supply
Class A	Ecstasy, LSD, heroin, cocaine, crack cocaine, magic mushrooms, amphetamine (if prepared for injection)	Up to 7 years in prison or an unlimited fine or both	Up to life in prison or an unlimited fine or both
Class B	Amphetamine, cannabis, methylphenidate (Ritalin), pholcodine, mephedrone	Up to 5 years in prison or an unlimited fine or both	Up to 14 years in prison or an unlimited fine or both
Class C	Tranquillisers, some painkillers, gamma hydroxybutyrate (GHB), ketamine	Up to 2 years in prison or an unlimited fine or both	Up to 14 years in prison or an unlimited fine or both

Source: Home Office, 2009a

Drugs are scheduled as either class A, B or C according to how damaging they are thought to be to individuals and communities. The different classes carry different penalties for possession and supply. A simple table (Table 1.1) is presented that helps to make sense of these classes.

All of the drugs identified in this schedule under the Misuse of Drugs Act are considered to be controlled substances and are illegal to use, except where they have been prescribed. Class A drugs are those that are thought to be the most dangerous to individuals, families and communities, while Class C drugs are thought to be the least harmful.

This scheduling system has been severely criticised over the years. According to Nutt et al. (2007) 'the process by which harms are determined is often undisclosed, and when made public can be ill-defined, opaque and seemingly arbitrary' (p. 1047). This appears to be due to the fact that drug-related harms are complex, multi-dimensional and evolve over time in unpredictable ways. Some drugs, like cannabis, have been moved between classes. For example, in 2004, cannabis was downgraded to a class C drug, only to be upgraded again in 2009 to class B because of concerns about the strength of hybrid types of cannabis known as 'skunk', and its detrimental effects to users' mental health.

It also appears, however, that history, politics and the subsequent discourse regarding what are 'good' substances and what are 'bad' substances (legal and illegal) has also influenced not only society's perception of these substances and those who use them, but also the official UK classification system and its associated penalties. This is especially true if we look at the research. According to Nutt et al.'s (2007) research based on experts' understandings of the scientific evidence of substance-related harm, if we kept the same structure for classification that is currently used in the UK and based it on 'harm', alcohol would almost certainly be classified as a class A drug, while ecstasy would probably be class C. That is, experts in the field believe that there is much more evidence to suggest that alcohol is overall far more harmful than ecstasy.

Based on these types of evidence, the Royal Society of Arts' (RSA) *Commission on Illegal Drugs, Communities and Public Policy* (2007) stated that the Misuse of Drugs Act should be repealed entirely and replaced with a Misuse of Substances Act which should incorporate alcohol, tobacco, solvents and over-the-counter and prescription drugs.

The 1980s

In 1979, there was another huge rise in the availability and use of heroin throughout most cities in the UK. This heroin was mostly from the Middle East and was smoked. By the early 1980s, there was huge public concern about this 'blight' on society, and the drug problem, especially the inner city heroin problem, became a serious political issue. In 1982, following a report from the ACMD, the Conservative government announced a central funding initiative to begin to establish a network of drug treatment services. This new funding, coupled with the HIV epidemic, saw a rapid change in UK drug policy (via recommendations from the ACMD) and the availability of services. The concern that HIV would be spread via injecting drug users meant that harm minimisation, methadone maintenance and needle exchange became a priority for drug services. Alongside these changes to drug services, the 1980s also saw a huge resurgence in the use of psychedelic drugs, namely ecstasy. This necessitated a further expansion in the repertoire of drug services which were used to working with injecting and other 'hard' drug users, and now had to begin thinking about ways of reaching out to drug users in the 'rave scene'.

The 1990s and beyond

Since the 1990s, consecutive governments have published a number of pertinent documents as well as developed comprehensive drug strategies in an attempt to reduce drug-related harm to individuals, families and communities. These drug strategies have included: *Tackling Drugs to Build a Better Britain* (Home Office, 1998); *Drugs: Protecting Families and Communities* (Home Office, 2008) and *The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem* (Scottish Government, 2008a). Under each of these strategies, a number of key initiatives were introduced, including:

- The establishment of Drug Action Teams (DATs) set up around the country to implement drug strategy at a local level.
- In 1997, the appointment of the UK's first 'drug czar' (the UK anti-drugs co-ordinator).
- In 2001, the establishment of the National Treatment Agency (NTA) to improve availability, capability and effectiveness of drug services.
- A substantial increase in the availability of drug treatment, including treatment accessed through the criminal justice system (Drug Intervention Programme).
- Drug supply and enforcement approaches.
- A focus on drug services working with drug-using parents.

- A focus on getting people into training, education and employment following their attendance at treatment services.
- A move from harm reduction strategies back to ‘recovery’ and abstinence focused strategies (for example, the Scottish Government’s (2008a) *The Road to Recovery: A New Approach to Tackling Scotland’s Drug Problem*).

It is clear, however, that despite these best efforts the demand for drugs remains. The makers and supplies of illicit substances are becoming more productive, and enforcement agencies cannot begin to compete with the criminal element that rules the illicit drug trade. According to a report by the RSA:

Drugs Policy in its present form has largely been a failure. We know it has substantially failed because in the nearly four decades since the Misuse of Drugs Act came into force the number of addicts and others dependent on drugs has soared and the social problems associated with substance abuse have worsened dramatically. (2007: 21)

Critics of prohibition still believe that we will never be able to reduce drug related harm until drugs are decriminalised and/or legalised, because the prohibitive nature of the regulation in itself can create harms for individuals and communities (Haden, 2006). Since the establishment of the Coalition government in 2010 the outlook for the health and social care sector appears uncertain. This is especially true given the release of the Coalition government’s new *Drug Strategy 2010 Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life* (Home Office, 2010). This Drug Strategy replaces the strategy *Drugs: Protecting Families and Communities* (Home Office, 2008) which had been established under the previous Labour government. The new strategy is structured around three themes: reducing demand, restricting supply and building recovery in communities. It has two overarching aims: to reduce illicit and other harmful drug use, and to increase the numbers recovering from substance dependence. It has a number of ambitious objectives and it remains to be seen whether these goals will be met in the future.

The UK Drugs Policy Commission (UKDPC) has historically been concerned that so little is known about ‘what works’ in regards to drug policy. They advocate for more resources to be put into further study and research into the components of the strategies so that regular and independent evaluation can be made regarding what is proving to be effective (UKDPC, 2007). They express concern that ‘tough’ measures and zero tolerance are ineffective. Continued focus on the implementation and evaluation of projects, programmes and initiatives that support the aims of any new Drug Strategy is paramount if its objectives are to be met.

According to Reuter and Stevens (2007):

The arena where government drug policy needs to focus further effort and where it can make an impact is in reducing the levels of drug related harms (crime, death and disease and other associated problems) through the expansion of and innovation in treatment and harm reduction services. (p. 11)

Alcohol policy and legislation

Issues related to problematic alcohol use have historically been superseded politically by the issues relating to problematic drug use; however, there have been a variety of responses to problematic alcohol use throughout the twentieth century and around the UK. Public health measures in the 1970s included a focus on alcohol awareness campaigns, education and prevention, while the adoption of drinking ‘units’ or ‘standard drinks’ in the 1980s helped to quantify and identify unsafe or problem drinking (Lloyd, 2010). Since this time, however, the issue of problematic alcohol use has become a major policy issue, with concerns about binge drinking, young people’s underage drinking and anti-social and disorderly behaviour leading to a number of government strategies focused on these areas. As a result of key alcohol harm reduction strategies (Prime Minister’s Strategy Unit, Cabinet Office, 2004; Department of Health (DoH), Home Office, Department for Education and Skills (DfES), Department of Culture, Media and Sport, 2007) these measures have included increasing the price of alcohol, controlling alcohol advertising, increasing the minimum age for buying alcohol, and restricting opportunities to buy alcohol. Other measures have included the advertising of health information on bottles of alcohol, in 2005 the implementation of the Licensing Act 2003 (which brought in ‘24-hour drinking’), sharpened criminal justice interventions for drunken behaviour, more help available for people who may want to drink less (telephone hotlines, websites and support groups), and where Scotland is concerned a focus on the importance of culture change aimed at ‘de-normalising’ alcohol consumption (Lloyd, 2010).

The Coalition government elected in 2010 criticised the previous Labour government’s alcohol strategy for having too much of a public order focus. The Coalition government suggests its alcohol strategy will be based on reducing demand through more public education and will include:

- A ban on the sale of alcohol below cost price.
- A review of alcohol taxation to tackle binge drinking.
- An overhaul of the Licensing Act to give local authorities and police more powers.
- A doubling of the fine for underage alcohol sales. (UK Alcohol Alert, 2010)

The actual changes to alcohol policy and legislation under the Coalition government, and their subsequent effects remain to be seen.

Historical legacy

There is no denying that substance use can be harmful (see Chapter 3), but there are also harms associated with prohibition. ‘Drug prohibition itself creates violence, crime, corruption, disease, and creates a robust black market, which

engages youth and makes drugs widely available' (Haden, 2006: 126). Alongside this, the harm that comes from having a criminal record can lead to unemployment, stigmatisation and benefit dependence, all of which probably does very little to reduce the likelihood of continued drug use. When social workers think about and work with service users who may have problematic substance use, it is important for them to recognise the potential harms from the criminalisation of drug use as well as the harms from the substance use itself.

It is also important to think about the reasons why some substances are illegal and others merely regulated, and why this may be the case. There are a number of theories on why this might be. For example, as we have seen earlier in this chapter, some of the first policies that sought to control the use of alcohol and other substances in the UK were aimed at the working class and were in effect 'classist'.

The 'war on drugs', especially in the United States, has also often been labelled as 'racist', and the influence of these policies internationally cannot be overlooked. Some examples of this include:

- Opium use linked predominantly to Chinese immigrants in the US at a time when anti-Chinese sentiment was being fuelled by concern about cheap Chinese labour. (This led to opium importation being prohibited and the US Chinese Exclusion Act of 1882.)
- Cocaine use being linked to black communities in the 1900s when stories proliferated about 'cocaine crazed negroes'.
- The use of cannabis by both black and white people who enjoyed the jazz music scene being used in the racist anti-marijuana propaganda which used this disintegration of racial barriers as an example of the degradation caused by marijuana.

Moral crusaders exploited endemic racism to spread the prohibition message by linking substance use with ethnic minority populations. Exaggerated claims and racial stereotyping featured prominently in the propaganda that was used to support prohibitionist legislation, which was further supported by the commercial sector and industry, which were worried about maintaining a productive, industrious and sober workforce (Woodiwiss, 1998). In the shadow of this history, policies including racial profiling and extensive sentencing for drug trafficking, dealing and drug use are still disproportionately carried out against minorities in both the UK and the US (Drug Policy Alliance, 2001; Ministry of Justice, 2009). The consequences of these disparities are evident in the poor economic and political health of the communities that those imprisoned leave behind. While policies and laws relating to substances, especially drugs, may no longer be as racist by design, they appear to remain racist (Provine, 2007).

Other hypotheses as to why some substances have been criminalised and others have not, include the argument that some policies have at their basis the protection of corporate profit. For example, it is argued that a legal opiate trade would be a huge competitor to the pharmaceutical industry. Conversely, alcohol which while regulated is still legal despite the harms it causes, means the liquor

industry remains a powerful economic player. Whatever the reasons, on the face of it the fact that some substances are illegal and some are not is difficult to understand. According to the House of Commons Science and Technology Committee (2006), the way that the Advisory Council on the Misuse of Drugs (ACMD) makes recommendations to the government about the classification of drugs is ad hoc, arbitrary and not based on evidence.

This short history of the use of substances helps us to appreciate better some of the context in which the current understandings of problematic substance use have developed. It appears that which substances have been made illegal and which remain merely regulated has not necessarily been based on scientific evidence of their harms and has been heavily influenced by social and political factors, including classism, racism and capitalism. This knowledge should help social workers understand that people who use substances, whether they are illegal or regulated, are not necessarily bad or immoral (as this is socially constructed) and therefore deserve a fair, equitable and non-discriminatory service.

Understanding the language

Language and definitions of problematic substance use, substance misuse, substance abuse, addiction and dependence still vary internationally and across professional disciplines. The disciplines of medicine and psychiatry still prefer 'addiction' and 'dependence' to encompass either physiological and/or psychological dependence on a substance or substances. The terms 'substance abuse' and 'dependence' continue to have diagnostic criteria for diagnosis included in the American Psychiatric Association's (2000) *Diagnostic and Statistical Manual of Mental Disorders*, and the World Health Organization's (1992) *ICD 10: International Classification of Mental and Behavioural Disorders*. Those working in the field of social work and social care, however, tend to use the term 'substance misuse' to include misuse and dependence on alcohol and/or drugs (Hafford-Letchfield and Nelson, 2008). The terms 'addiction', 'substance abuse' and 'substance misuse' while still commonly used have culturally constructed negative connotations attached to them, which as social workers we must try to move away from. The term 'problematic substance use' is used throughout this text to include the entire continuum of problematic substance use from severe end dependence through to problem use. This language also identifies the problem as being with the use of the substance (including alcohol), rather than a problem with the person who uses the substances. Such contested use of language is indicative of the struggle between practitioners, service users, patients, government, medicine and psychology for authority in theorising about problematic substance use and providing treatment solutions.

Theory and models

Objective knowledge about problematic substance use has been developed over time from a variety of hypotheses and studies of substances and the people who use them. Models and theories about problematic substance use include the

‘moral model’ – where substance users are seen as ‘sinful’ and ‘weak willed’ – the ‘disease’ model (Jellinek, 1960; Levine, 1978), as well as psychological (Reinout and Stacy, 2005), genetic (Blum et al., 1990), social learning (George, 1989) and socio-cultural models of understanding (Furnham and Thompson, 1996).

Disease models have probably been the most historically significant, as this concept underpins the powerful and popular 12-step fellowship programmes, including Alcoholics Anonymous (www.alcoholics-anonymous.org.uk) and Narcotics Anonymous (www.ukna.org) that have been influential in providing substantial support for people with problematic substance use worldwide. The ‘disease’ model perceives ‘substance misuse’ as the behavioural consequence of pre-existing and permanent physical vulnerability that ‘addicts’ have to substances (Barber, 2002). Behavioural learning theories emphasise the influence of learning to use substances through personal experience and the influence of others such as parents, peers, the media or other sources. This theory also encompasses socio-cultural perspectives, where the use of substances can be seen as helping to alleviate personal and social difficulty by ‘self medicating against life’s negative experiences’ (Taggart et al., 2007: 360), thus reinforcing substance-using behaviour. What is clear is that environmental influences cannot easily be separated from genetic ones (Hafford-Letchfield and Nelson, 2008). None of these theories, however, really provides us with all the answers to problematic substance use, as there are a remarkable number of variables that may contribute to some people developing problematic substance use where others do not. These variables are often referred to as ‘risk’ and ‘protective’ factors.

Risk and protective factors

What causes individuals to develop problems with their use of substances will be different for different people. However, there have been a number of ‘risk’ and ‘protective’ factors that have been identified. These are variables that are thought to put people at risk of developing problematic substance use or conversely may provide some protection from problems. Social workers may find these factors helpful as a guideline when seeking to understand service users with problematic substance use. According to the American National Institute on Drug Abuse (NIDA) (2008) the risk and protective factors to look out for come in five domains. These five domains are individual, family, peer, school and community. Risk and protective factors are often associated with experiences that people have had in their childhood. ‘Children’s earliest interactions within the family are crucial to their healthy development and risk for drug abuse’ (NIDA, 2008: 1). Risk factors are associated with negative behaviours or experiences in each of these domains, while protective factors are seen as useful or positive behaviours, experiences and support in each of these domains.

We know that a lot more people use substances than develop problematic substance use. Thinking about risk and protective factors helps us to identify why some people may be more likely to develop problematic substance use than others. For instance, it is not unusual for higher education students to experiment

Table 1.2 Risk and protective factors for problematic substance abuse

Risk factors	Domain	Protective factors
Early aggressive behaviour	Individual	Self-control
Poor social skills	Individual	Positive relationships
Lack of parental supervision	Family	Parental supervision
Substance use	Peer	Academic achievement
Substances easily available	School	Substances difficult to get
Poverty	Community	Strong sense of positive community

Source: Adapted from the American National Institute on Drug Abuse (NIDA), 2008

with the use of substances, but not all of them will develop problematic substance use. This might be because they have a number of protective factors working for them, and very few risk factors. For example, it is likely that many students entering into higher education have good family support, positive relationships and academic competence, compared to young people from deprived communities who may have left school early and be unemployed (risk factors). Adverse life events in childhood (like abuse and neglect) and beyond, lead to limited opportunities and put people at risk of being more likely to develop problematic substance use. Some examples of risk and protective factors that you should be aware of are noted in Table 1.2.

With the confusion and lack of consensus around what causes and sustains problematic substance use, it may be more helpful that social workers are aware of these factors rather than know all the details of the vast number of theories that there are about problematic substance use. It is important to note, however, that even if someone presents with all of these risk factors, it does not necessarily mean that a problem will develop, and conversely someone with a number of these protective factors may still develop a problem. Use them purely as a guide to your work with service users.

Summary

History provides us with some understanding of how and why we view substances and the people who use them the way we do. Substances have not always been illegal or highly regulated, or seen as immoral, and have been used for centuries in many communities around the world. Real concern regarding health and social problems, alongside socio-cultural and political agendas, have influenced the medicalisation, criminalisation and subsequent prohibition and regulation of substances. This in turn has led to marginalisation for people in our societies who use substances. The historical context has also influenced the language we use and the theories and models that try to explain problematic substance use. There are no clear and precise understandings of problematic substance use; however, there are some real risk and protective factors that are useful for us to be aware of when working with service users who have problematic substance use.

Since the 1960s, there have been a number of policies and strategies throughout the UK aimed at reducing the harm of alcohol and other drugs, to individuals, families and communities. Governments have implemented a variety of measures, including ongoing education and communication to reduce substance-related harm, supply-side enforcement, enforcement to reduce anti-social behaviour and crime associated with alcohol and drug use, and faster access to better drug treatment services. Critics of policy argue that we do not know enough about what is working in regards to drug policy and that too often zero tolerance and so-called 'tough' measures that are unsupported by the evidence are counterproductive (UKDPC, 2007). While previous governments have readily accepted that a focus on harm reduction measures is integral, the Coalition government's drug strategy (Home Office, 2010) focuses on the importance of 'recovery' for individuals and communities with problematic substance use. What is clear is that any new alcohol or drug strategy needs to be more aligned to evidence-based interventions, and that more rigorous and independent research is needed to evaluate its effectiveness.

Reflections

Think about your own personal views of people who may use substances. If you are honest about this, what do you think of them?

Does understanding some of the history of substance use and how it has influenced contemporary thinking change your views at all? If so, in what ways?

Have you been aware of some of the strategies outlined in this chapter? For example, were you aware that raising the level of tax on alcohol and limiting alcohol advertising sought to reduce alcohol-related harm. Do you believe that any of these strategies have been effective?

Further readings

Davenport-Hines, R. (2004) *The Pursuit of Oblivion: A Social History of Drugs*. London: Phoenix.

Lloyd, C. (2010) 'How we got to where we are now', in J. Barlow (ed.), *Substance Misuse: The Implications of Research, Policy and Practice*. London: Jessica Kingsley Publishers, pp. 19–38.