

Moving Beyond 'People-First' Language

*A glossary of contested
terms in substance use*



SDF
Scottish Drugs
Forum

Foreword

Committed engagement from stakeholders across the drugs field means that the field remains one in which discussion and debate has flourished. This discourse exists within the public realm and reflects the values and instincts of the public as well as those of professionals and academics and, crucially, the opinions and experiences of people who use drugs.

One of the issues in such a complex discourse with so many stakeholders is that language develops that excludes some stakeholders. Some professional and academic discourse is unintelligible to people whose specialist knowledge and perspective lies outwith the professional or the academic world. Likewise, there is a rich language amongst people who use drugs to describe their experiences and communicate with each other. Some of this, given the illegal and sometimes clandestine nature of drug use is deliberately exclusive of others.

A glossary of all the terms used would be a huge undertaking. This project sought to identify terms that are contested or commonly misunderstood. The aim has been to explain the nature of contention and, where terms may be misunderstood, account for this. Where appropriate, SDF's own preferred use of language is given and explained.

The drugs field contains a lot of language that is offensive to some people. This is because drug use is a stigmatised activity. People who use drugs; people who have a drug problem; people in treatment and people who may be regarded as being in recovery all suffer stigma as do their families and communities. Self-stigma means that people may use stigmatising terms to describe themselves and their situation. The issue is delicate and complex.

This resource allows people to understand contested terms and understand how language can result from and perpetuate stigma. In Scotland, there is an emerging consensus on the use of people-first language – using 'people who use drugs' rather than 'drug users' or 'drug misusers' or 'addicts', for example. There has also been a commitment in the latest drug strategy to use acceptable terms. However, there is a long way to go. We cannot continue to think that people can be included or supported, never mind empowered, by people and services that have adopted languages and notions which reflect and perpetuate societal stigma.

The hope is that this resource will help support people to reflect and change their use of language and be sensitive to the fact that language can betray miscomprehensions, prejudices and stigma that sustain the marginalisation and disempowerment of people, some of whom are amongst the most vulnerable people in Scottish society.

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Introduction

The drugs field deploys a huge range of technical terms and jargon. Much of this is borrowed from other fields – medicine, research, statistics, sociology etc. There are also terms used by people who use drugs and terms specific to treatment and recovery contexts. Of course, most of these terms are adequately defined in a good dictionary.

However, there are terms which have become key terms within the drugs field which involve some specialist knowledge to fully understand their significance. Some of this terminology is contested or commonly misunderstood. There is also a wider discourse around drugs, drug use and related issues that involves people who use drugs, the media and the wider public. Some of the language used within this wider sphere is contentious or misunderstood.

This glossary was developed originally for SDF board members, staff, trainees and volunteers. In publishing it, SDF aims to improve communication and shared understanding across the drugs field in Scotland by increasing understanding of the language used both in everyday conversation and discussion of drug issues and in more specialist environments. This glossary clarifies the nature of any contention so that people can at least understand the viewpoints of others and, hopefully, any limitation in their own insight, when they cannot agree. SDF's own organisational language choices are explained.

SDF has stakeholders who use all of the terms described here and it is important to us that as far as possible, people can understand each other and that unnecessary contention or conflict across the drugs field can be eliminated.

Language is evolving and this resource will be revised and updated. If you have any comment on the content or suggestions for terms that should be included, please do not hesitate to get in touch.

SDF acknowledges and is grateful for the support of stakeholders who have contributed to the discussions from which this work has evolved.

Please note that SDF does not assert its rights as an author and this glossary is 'open source'. People should feel free to re-use this material. If you want to credit SDF as author, we would, of course, be appreciative.

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Abstinence

The term 'abstinence' refers to the state of not using substances and is a contested term for several reasons.

Abstinence can be defined in several different ways. For example, abstinence may include abstaining from the use of

- substances that a person has previously used problematically
- substances that are illegal
- substances that are psychoactive
- substances to which a dependence can develop such as caffeine and nicotine and some medication
- prescribed medication

Even when a definition is agreed, the significance of abstinence is disputed. For some people, abstinence is an end in itself. This leads to phrases like 'achieving abstinence'. For some people abstinence defines, or helps to define, 'recovery'. (see **recovery**)

In other circumstances, or for other people, abstinence is simply a state of being which may be temporary or permanent but does not necessarily have particular significance.

For people who use abstinence to define recovery, different definitions of abstinence can cause issues if people who regard themselves as abstinent and in recovery compare and judge others who regard themselves as abstinent and in recovery but define abstinence in a different way. While peer pressure can be helpful and support people in making progress in their lives, it can also be destructive and divisive.

Some common inferences about abstinence are not borne out in experience. For example, it cannot be assumed that a person who is abstinent is necessarily 'better off' or 'more well' than someone who is not. (see **'better than well'**) For example, when they stop using drugs, a person who has been self-medicating for mental health issues associated with trauma may find that their mental health symptoms become more apparent and severe and may seem overwhelming. (see **self-medicating**) Also, it is hard to sustain a case that someone involved in occasional controlled use of substances is by definition less healthy or 'worse off' than someone who is abstinent. (see **recreational use**)

Abstinence is an unusual human state. The evidence is that all through human history back to the beginning of recorded history and across human geography the use of substances is common. Substance use has been shaped by religious and legal strictures and different forms of taboo and stigma have developed within societies. (see **stigma**) However, examples of the complete elimination of substance use in societies are limited and have always been temporary.

It is commonly stated that people who present at treatment services or who have a drug problem want to be abstinent. If evidence is cited for this, it is usually a 2004 paper by Neil

McKeganey (citation below) However, it should be noted that Joanne Neale, a co-author of that paper, later wrote to effectively dispute both the methodology of the research and the interpretation of the data.(see citation below).

The claim that 'people want abstinence' is heavily contested and unhelpful if it is used to imply that people in treatment who are on OST, for example, are in this treatment against their will or that their treatment does not support them in addressing at least some of the issues they face.

McKeganey, N. et al (2004) What are drug users looking for when they contact drug services: abstinence or harm reduction? Drugs: Education, Prevention, and Policy Vol 11 pp 423-43

Neale, J et al (2011) What is the role of harm reduction when drug users say they want abstinence? International Journal of Drug Policy Vol 2.3 pp 189-193

SDF uses the terms abstinent or abstinence – usually explicitly stating the substances from which a person is abstinent e.g. 'abstinent from illegal drugs' or 'abstinent from stimulants'



In its work, SDF uses the evidence of the author of the research most often cited to point out that there is no substantial evidence that all 'people want abstinence' or that treatment or wider services should solely focus on abstinence as an outcome, while arguing for a person-centred approach within services and the empowerment of people using services to articulate and explore their own needs and desires and control their own treatment in therapeutic, supportive and trusting relationships with service staff and others.



Explore further:

Norman E Zinberg Drug Set and Setting
<https://www.youtube.com/watch?v=JgrxLqhcXOo>

'What Do Patients Want?' Drug & Alcohol Findings 2016
https://findings.org.uk/PHP/dl.php?file=patient_centred.hot&s=eb&sf=sfnos

Addict

The term 'addict' has a diverse range of meanings, some of which may be personal to individuals who may regard themselves and describe themselves as 'addicts'. It may also be used in ways which are dehumanising, disempowering and stigmatising.

Some people find identifying as an addict helps them better understand their own experiences and more able to describe or explain these experiences, and their situation, to others. In this sense, for some people, at certain times, the term addict can be personally empowering.

However, the term addict may also be used in a way that is offensive or derogatory. It may be used in a way that is dismissive of the detail and personal aspects of a person's situation and so be dehumanising. It may be used to 'sum up' someone in a single word in a way that is disempowering.

The term may be used as a label to categorise someone in a way that implies that they cannot develop or change themselves and be supported by others to change. When used in this way it may mean that people are not helped or supported by individuals or by services.

For some people, the term may be viewed as simplistic and overly clinical – sounding like a diagnosis of a disease.

The term may be regarded as too imprecise, describing a huge range of people with different life experiences who may have little in common. On the other hand, other people may feel that there are commonalities between 'addicts' that are suggested by describing them as such. However, these commonalities may be inaccurate or stigmatising and lead to unhelpful and stigmatising generalisations.

The term is also open to interrogation as to whether it is a valid term at all as it depends on the notion of addiction (see **addiction**; see **disease model**; see **drug, set and setting**).

In its work, SDF does not use the term addict but, of course, accepts that some people will want to describe themselves in this way. If it is necessary to indicate that someone regards and describes themselves as an 'addict' the term would be used in quotes.



Instead SDF may, depending on the circumstance, use terms like:

- person with a drug problem
- person with a drug dependency
- person with problem drug use

For some people, the people-first language term 'person with an addiction' may address some of the issues described here. In its work, SDF avoids using this term (see addiction).

Addiction

Although widely used, the term addiction is disputed as it has a range of definitions and uses. Some people who describe their experiences and behaviour as an addiction or who are described as having an addiction can have very personal and specific definitions of addiction.

Even where definitions are agreed, there are different views on the significance of addiction.

As a medical term, drug addiction is described as a chronic, relapsing disease characterised by compulsive drug seeking and use, despite serious adverse consequences, and by long-lasting changes in the brain. All aspects of this definition are open to challenge; as is the notion that addiction can always and usefully be regarded as a disease. (see **disease model**)

The notion that problem substance use is hereditary is sometimes proposed. There is much evidence to counter this and suggest that problem substance use is closely related to poverty and childhood trauma (see **poverty**, see **adverse childhood experiences**) trauma in adulthood; (see **trauma**) and social situation (see **drug, set and setting**; see **Vietnam veteran studies**; see **Rat Park**)

In its work, SDF avoids use of the term addiction to describe individuals' experiences.



Instead SDF may, depending on the circumstance, use terms like:

- dependency
- drug problem
- problem substance use

SDF does sometimes use the term addiction as an adjective to describe treatment services for people with a substance use problem i.e. 'addiction services' or where it is used by professionals, for example 'addiction worker' or in medicine, for example 'addiction psychiatry'.

Addictive or addictiveness

People commonly report that daily or frequent use over a period of months or even daily use over a period of weeks is enough to establish dependency on some substances. There are claims, sometimes from people with a dependency, but usually in the media that people can be 'hooked' the first time they use a substance. There is no evidence for this.

There is also widespread mention of certain substances as being 'highly addictive' or statements like 'methadone is more addictive than heroin'. The evidence for the notion of different levels of 'addictiveness' is limited. The intrinsic 'addictiveness' of a substance, if it exists, seems far less important a factor than the person (see **adverse childhood experiences**; see **trauma**; see **poverty**) and the situation they are in (see **drug, set and setting** ; see **Vietnam veteran studies**; see **Rat Park**)

Factors that may affect how easy it is to develop or overcome a dependency may include

- availability of a substance
- acceptability of the substance within your social group
- peer pressure and role models
- relationships with people who do not use / people who use
- having control over your life, opportunity and choice
- having alternative things to do and motivation to do these things
- past experience of trauma
- experience of mental health problems
- experience of physical health problems
- current ability to focus on future
- current ability to prioritise long term health and other issues

In its work, SDF does not generally refer to the 'addictiveness' of substances and does not use terms like 'highly addictive'. Instead SDF is more likely to focus on the social context of substance use and the personal experience and situation of the person using substances.



SDF is keen to develop a shared understanding of the physical, psychological and social aspects of dependency. One aspect of this work is supporting the contribution of people with experience of dependency in discussion of these issues; another aspect is ensuring that there is awareness and understanding of the research and experiential evidence of stakeholders across the field.

Adverse Childhood Experiences (ACEs)

Adverse Childhood Experiences (ACEs) are used to explain and predict the health issues people will experience as a consequence of circumstances or events in their childhood. This perspective has a growing popularity in Scotland over a whole range of settings including health, education and criminal justice.

The evidence base for ACEs is chiefly the original ACE Study conducted at Kaiser Permanente from 1995 to 1997. Over 17,000 Health Maintenance Organization members from Southern California received physical exams, completed surveys about their childhood experiences and current health status and behaviour.

The data by which an ACE score is determined are simply the number of 'yes' responses to ten questions about what happened to someone before their 18th birthday:

1. Emotional abuse by a parent, step-parent or adult living with the child involving feeling physically threatened
2. Physical abuse by a parent, step-parent or adult living with the child that left marks or injury
3. Sexual abuse of any kind by any person 5 or more years older than the child
4. A mother or stepmother who was violently abused by her partner
5. A member of the household who had a substance use problem
6. A member of the household who had a mental health problem
7. A member of the household who was imprisoned
8. Parental separation or divorce
9. Emotional neglect defined as family not being a source of strength and support
10. Physical neglect defined as family / household member not taking physical care of the child

All adults, then, can receive an ACEs score of 0-10

This, and subsequent studies, show links between the ACEs score and health outcomes, including problem substance use. Perhaps not surprisingly to people experienced in meeting or working with people who have a substance use problem, or to people who have experienced problem substance use, the higher someone's ACE score, the more likely it is that they have a substance use problem in their adult life.

This analysis and insight is useful but it is limited. It is open to criticism because the ACEs study ignores the social context and conditions in which people are born, grow up and live their adult life. It focusses on parental behaviour and circumstances within the family home only – ignoring, for example, unemployment, acts of violence perpetrated outwith the home, poverty, education, sexism, racism and class. (see **poverty**)

It also relies entirely on self-reporting. It depends on adults being able to recall, and being willing and able to disclose, the existence of painful episodes from their childhood reliably. Even when this is possible, people may well recall their childhood in ways that explain their current situation. For example a healthy and happy adult may not report or even recall their father's one-off act of extreme violence in the family home as they view it as insignificant or

not worth mentioning; whereas someone who has faced difficulties in their adult life including poor health may report the same childhood experience as they feel it is significant or helps explain or 'justify' their current situation – they may have revisited this experience as part of their engagement in treatment and it may now have significance for them.

The ACEs questionnaire is simple and crude. The subsequent work implies that -

- all abuse and neglect; all parental separations; all household substance use issues have the same traumatic impact on a child no matter how the child is otherwise supported
- all childhood trauma has the same impact whether the child is a few months old, a young child or a young person aged up to 18
- all violence within a home has the same impact whether it is a single incident or repeated and no matter the degree of violence involved.

Many people, and other evidence, would contest these implications of the ACEs research.

The discourse that has developed around ACEs lays responsibility for health in adulthood almost entirely on the child's household. Wider community and society are 'let off' any responsibility or role. This is a political view that ignores much of the long-standing and well-researched evidence on wider determinants of health. While ACEs is a more sophisticated analysis it suffers shortcomings similar to the shortcomings of the political notion that substance use and by implication problem substance use is a lifestyle choice (see **lifestyle choice**).

The ACEs research has been useful in helping some people who have a substance problem to understand the connection between experiences in childhood over which they had no control and their current issues. This has been empowering for people who were otherwise left to feel guilt or that they were somehow inadequate or different from other people. (see **addict**; see **disease model**)

The ACEs research also contributes to understanding of why problem drug use may occur in families and why some people who have a substance problem have had a parent or a sibling with a substance problem. It therefore counters the notion that problem substance use is hereditary. (see **could happen to anyone**)

The ACEs research has similarly helped address some stigma by demonstrating that people who have a substance problem are not 'bad' or 'lacking willpower' or making 'bad choices' or choosing to 'indulge themselves'; that their problems are rooted in situations in their past which most people will regard as unpleasant and unfortunate and with which some people will empathise. (see stigma) However, some people may be less empathetic. Reactions like 'well my father was violent and I didn't become a heroin user' illustrate this and are based on both misinterpretations of the ACEs evidence and the shortcomings of the ACEs analysis.

The ACEs research is a very good basis from which to advocate early intervention and support for vulnerable households.

In its work, SDF uses the evidence of the ACEs research while emphasising there are other wider well-evidenced social determinants of health and that these include poverty and access to services. SDF points out that these offer a fuller perspective on problem substance use.



SDF uses the ACEs research in advocating for early supports for families and households with children as a significant means to prevent problem drug use and other serious impacts on health and well-being.



Explore further:

Gabor Mate: Drugs, Set and Setting International Drug Policy Reform Conference 2011

www.youtube.com/watch?v=MNatUMUAmxg

Public Health Scotland: Adverse Childhood Experiences (ACEs)

www.healthscotland.scot/population-groups/children/adverse-childhood-experiences-aces/overview-of-aces

Scottish Government: Adverse Childhood Experiences (ACEs)

www.gov.scot/publications/adverse-childhood-experiences

Aces Too High

acestoohigh.com

US Government Centers For Disease Control and Prevention: Adverse Childhood Experiences (ACEs)

www.cdc.gov/violenceprevention/cestudy/index.html

Advocacy

Advocacy is not commonly available to people who have a substance use problem but there has recently been more focus on this. This has involved some confusion by what is meant by the term advocacy.

In the mental health field, under the Mental Health (Care and Treatment) (Scotland) Act 2003, independent advocacy is available to people engaging with services and is in place to ensure their wishes as well as their needs are delivered and met in circumstances in which their health may prevent them communicating their needs and desires, fully participating in decision making or ensuring their rights are protected in a relationship with services which involves a crucial power imbalance between those providing and those receiving the service. It is important to note that independent advocates therefore take instruction from and act on behalf of their clients – not in pursuing a pre-determined end supported by the advocate or the service-providing organisation.

The Scottish Government drugs strategy document Rights, Respect and Recovery mentions a plan to invest in 'independent advocacy' to ensure a rights-based approach for people with a substance use problem in engaging with services. It is presumed that independent advocacy as used in the mental health field provides a model for this.

However, in the substance use field, advocacy is not legally defined. The term 'advocacy' is sometimes used to describe something closer to supporting people towards a particular end, specifically abstinence recovery. Thus 'recovery advocacy' has become a more commonly used term. Advocacy, in this circumstance, does not necessarily mean advocacy on behalf of a person in pursuit of their rights nor, necessarily, their stated wishes but on behalf of a process supported and promoted by others.

In its work, SDF uses the term advocacy in a sense defined in the Mental Health (Care and Treatment) (Scotland) Act and in terms used by The Scottish Independent Advocacy Alliance.



SDF supports independent advocacy for people who are using drug treatment and other services. It promotes this role citing the existence of such support in mental health contexts.



Explore further:

SIAA (2017) Advocating for Human Rights
www.siaa.org.uk/wp-content/uploads/2017/09/SIAA_Advocating_Human_Rights_Guide.pdf

SIAA (2010) Available for All? A report on independent advocacy for individuals with problem drug use in Scotland
www.siaa.org.uk/wp-content/uploads/2014/02/SIAA_Available_for_all.pdf

Scottish Executive (2004) Advocacy for Drug Users: A Guide
docs.scie-socialcareonline.org.uk/fulltext/advdrug.pdf

Alcohol and other drugs

This term for psychoactive substances has developed to ensure that alcohol is regarded, accurately, as a drug or a psychoactive substance. This is regarded as helpful in some contexts both in ensuring that alcohol is not regarded as exceptional or different and in ensuring that drugs are not regarded as essentially different from alcohol and other socially acceptable forms of substance use. In this latter sense, the term can help destigmatise drug use or reduce the hierarchy of stigma that is associated with the use of different substances. (see **stigma**)

The term is also sometimes useful in referring to polysubstance use involving alcohol; especially where there is a possibility an audience may regard alcohol use as normal or a 'given' or not significant; for example, in some discussions of drug related deaths the role of alcohol in polysubstance drug overdose sometimes needs to be made clear.

In its work SDF sometimes uses this term where context makes it useful.



However, instead SDF may, depending on the circumstance, use terms like:

- substances
- all substances
- substances including alcohol

Alcohol abuse or alcohol misuse

These terms are used to differentiate 'normal' alcohol use or 'recreational alcohol use' from 'problem alcohol use'. These terms are contested. The distinction between these two behaviours can be very difficult to define. These are not fixed behaviours - an individual may drift between the two behaviours, no matter how they are defined (see **recreational drug use**).

The terms abuse and misuse and contested being regarded by some people as judgemental, moralistic and inaccurate.

The terms may be regarded as inaccurate or stigmatising as people drink to get intoxicated. Although some people claim they do not drink alcohol to become intoxicated, the fact is that few people would be able to drive legally after a drinking session. People can become intoxicated after a single drink. In becoming intoxicated, people are not using the product for a purpose other than the purpose for which it was manufactured and supplied so they are not abusing or misusing alcohol.

It could be argued that for someone with an alcohol dependency, alcohol use is necessary to prevent life-threatening withdrawal – in what way is this person's use of alcohol 'abuse' or 'misuse'?

The term may be regarded as derogatory or stigmatising to people with an alcohol-based substance problem as it promotes the idea that that kind of use is wholly distinct from other people's use of the same substance.

In the field of public health, this term may be unhelpful as, for some health outcomes, no level of alcohol use can be regarded as wholly safe or unharmed as these terms imply.

In its work, SDF does not use these terms. Instead SDF may, depending on the circumstance, use terms like:



- alcohol use
- problem alcohol use

Alcoholic

A term used for a person who is dependent on alcohol.

While some people self-identify as 'alcoholic' or 'an alcoholic', this term can be derogatory or even abusive. (See **addict** for full explanation of the issues with these terms.)

Some people regard this term as overly-medical as it has been used as term of diagnosis (see **alcoholism**; see **disease model**)

In its work, SDF does not use this term to describe people, while accepting that people may feel comfortable or even empowered by describing themselves in this way.



Instead SDF may, depending on the circumstance, use terms like:

- person with an alcohol problem
- people with an alcohol-based substance problem.

SDF uses this term only as an adjective as in the phrase 'alcoholic drink', for example.

Alcoholics Anonymous (Narcotics Anonymous, Cocaine Anonymous and SMART Recovery)

The original anonymous fellowship offering peer support through its twelve step programme was established in Akron, Ohio USA in 1935 by two 'alcoholics', Bill W. and Dr. Bob.

AA groups are established by peers coming together and replicating very similar groups using AA's Traditions and the 12 step programme as their guide and model.

In Scotland, AA is long established and there are many AA groups and meetings. The tradition of anonymity means that the number of people involved with fellowships, and whether that number is increasing or decreasing, are unknown.

Similar fellowships now exist for users of other substances – Narcotics Anonymous for people with a drug problem and Cocaine Anonymous for people with a drug problem involving stimulants. In practice, anyone who expresses a desire and determination to stop using substances can attend meetings of any fellowship.

The emergence of SMART Recovery was promoted as offering 'a secular 12 step'.

A small number of services have close links with 12 step fellowships; other professionals in the field may mention the existence of groups and meetings and point out possible benefits to individuals; others merely advertise the existence of groups and meetings with posters on notice boards etc.

The perception that fellowships are a quasi-religious groups (the mention of a "Power greater than ourselves" in Step Two or "God" in Tradition Two); the tradition of anonymity; the existence of 'closed' meetings which exclude non-members and the self-regulating nature of the organisation have made some people, including some professionals in the wider field, cautious about engaging with AA and even suspicious of the organisation. The fellowships have, within their traditions, tried to alleviate some of these concerns, chiefly by engaging professionals in the substance use field, and others, in open meetings and producing literature explaining the fellowships' approach.

Some of the fellowships' traditions, particularly the tradition of anonymity, have meant that elements of the more visible 'recovery movement' have criticised anonymous fellowships, even claiming that anonymity promotes or sustains stigma (see **stigma**). However, many people in anonymous fellowships are also involved in public recovery activity including demonstrations, volunteering and media work as well as working in the drugs field where they may disclose their own personal history and involvement with fellowships. (see **peer workers**)

In its work, SDF recognises and respects the support and positive engagement many people receive and give in their involvement with fellowships. SDF recognises other people will not feel able to, or want to, be involved and that a person-centred approach means that there should be no compulsory or coerced engagement or non-engagement with any service or group.



Also, SDF respects anonymous fellowships' autonomy and desire to remain separate from other bodies and notes that the 12 traditions include the determination that groups ought to be fully self-supporting; decline outside contributions; remain 'non-professional' and have no opinion on outside issues. SDF also notes and the traditions state that fellowships' public relations policy is based on attraction rather than promotion.

Alcoholism

There are significant issues with this term which means that it is often contested (see **addiction**).

Alcohol Use Disorders are medical diagnoses established in DSM-5 which defines alcohol use disorder (AUD) with mild, moderate, and severe sub-classifications. Anyone meeting any two of the eleven criteria during the same 12-month period would receive a diagnosis of AUD. The severity of AUD—mild, moderate, or severe—is based on the number of criteria met. All 11 criteria are self-reported situations or behaviours such as 'having spent a lot of time drinking or getting over the after-effects' or 'having times when you drank more or longer than you intended'

A body such as the US National Institute of Alcohol Abuse and Alcoholism describes alcohol use disorder as "a chronic relapsing brain disorder characterized by an impaired ability to stop or control alcohol use despite adverse social, occupational, or health consequences." All aspects of this definition are open to challenge as is the notion that 'alcoholism' is a disease. (see **addiction**; see **disease model**; see **drug, set and setting**; see **Rat Park**)

In some circumstances, the term alcohol dependency, which can be more accurately defined, may be more appropriate than alcoholism.

In its work, SDF avoids use of the term alcoholism. Instead SDF may, depending on the circumstance, use terms like:

- alcohol dependency
- problem alcohol use
- problem substance use involving alcohol



Assets-based approach

As currently used within health and other discourses in Scotland this term has no fixed meaning. It is sometimes used in the vaguest sense to refer to something akin to 'being positive' or 'focussing on what resources people have to address their own issues'.

The term and the approach are contested.

Notions of asset-based approaches have been around for several decades – originating in community development in the USA and popularised in the Reaganite 1980s when cuts to community development resources were ideologically justified by a 'focus on assets'.

For some, 'focussing on assets' means ignoring the power dynamics within society and the potential role of the state in addressing these when they cause inequalities like health inequalities. For some people, the focus on assets ignores issues around class and poverty and other social determinants of health. (see **Adverse Childhood Experiences** for a similar argument)

Despite numerous productions of 'good practice', there is an absence of evidence that a 'focus on assets' or an asset-based approach improves health or addresses health inequalities. However, some workers are energised by an approach that itemises assets rather than measuring need, despite the lack of evidence that this is effective.

There is criticism that an asset-based approaches ignores or takes insufficient account of the power dynamics between, for example, professionals, elected representatives and members of the public and particularly people who are marginalised or members of marginalised groups. It is argued that while the discourse around asset-based approaches involves reference to empowerment, this is of a limited kind taking no or insufficient account of people's rights and entitlement.

There is also frustration, amongst advocates and critics, that an asset-based approach is still regarded as 'new' or something that people do not understand, decades after it was first introduced. For some people, this suggests there are flaws in the analysis that brought forth the approach in the first place; for others this shows that services and service staff are in fact part of the problem or an obstacle to addressing issues.

SDF supports the empowerment and involvement of people affected by issues in designing, commissioning, managing and delivering the services and supports from which they benefit or could benefit. SDF supports activity and approaches that support this. Work which is described as 'assets-based' sometimes meets this criterion and sometimes does not.



In its work, SDF avoids use of this contested terminology but rather refers, as appropriate to empowerment, user-led initiatives and user involvement in the design, commissioning, management and delivery of services; and also to person-centred service delivery.



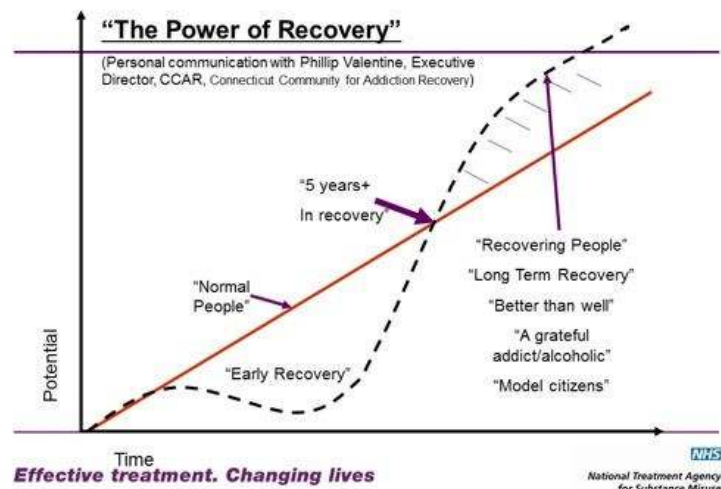
Explore further:

Rippon, Simon & Hopkins, Trevor. (2015) *Head, hands and heart: asset-based approaches in health care; A review of the conceptual evidence and case studies of asset-based approaches in health, care and wellbeing*

MacLeod, Mary & Emejulu, Akwugo. (2014). *Neoliberalism With a Community Face? A Critical Analysis of Asset-Based Community Development in Scotland. Journal of Community Practice*. 22. 430-450. 10.1080/10705422.2014.959147

'Better than well'

The idea that people who are in abstinent recovery are 'better than well' has been around for over a decade. This seems to have been popularised by a graphic produced by the National Treatment Agency in England in 2010 (see below) that contained a graph that 'showed' this. This curious artifact is not the result of research or any statistical analysis. It is labelled as being the product of a "discussion with Phillip Valentine, Executive Director CCAR". CCAR is a private healthcare provider in the US state of Connecticut.



Subsequently, UK research seemed to explore two related issues - either that people who are in abstinent recovery from problem substance use are 'better' than they would have been if they had never had a substance problem or that people in this situation are 'better' than the general population.

For example, a study in Birmingham (Hibbert and Best, 2011) of 53 older people in abstinent recovery from problem alcohol use 'reported higher scores in the social and environmental elements of their Quality of Life measurement' and proposed these scores 'may exceed those in the general population'. To quote one paper (Collins, A and McCamley, A (2018). "These studies contributed to recovery being conceived as less a return to 'normal', but more as a process towards higher levels of appreciation and fulfilment of quality of life".

There is some confusion here. Is it postulated that people in recovery are necessarily 'better' than they would have been without having had a substance use problem? This suggests that developing a serious substance use problem that may last years and result in significant health and other issues, should be regarded as a positive lifestyle choice as it has positive impacts on long term health. This may run counter to the personal experience of vast majority of people who have had a long-term substance use problem. Also, in terms of research methodology how would one prove such a thing? Who could know what trajectory a life may have taken if years and sometimes decades had been lived in very different circumstances than they actually were?

The research quoted is based on self-reported personal perceptions of health and wider well-being of 53 middle aged men in recovery from an alcohol problem. The researchers then seem to have compared these scores with those of the national average for a comparator population. An argument that someone in abstinent recovery from problem alcohol use is actually better off in terms of health and well-being etc than the general population would be very hard to sustain. The health of many people who have had substance use problem is often hugely compromised by the impact of substance use.

Some of these papers, and the NTA graphic referred to above, use language like 'a grateful addict'. This takes us closer to the thrust of what 'better than well' actually means – that people who have been through difficult situations including problem substance use are sometimes grateful for things that other people can sometimes take for granted – this is a long way from being 'better than well' and from the way this term is often used.

It may seem odd that the NHS in England would promote the notion that the purpose of treatment should be to create 'grateful addicts' or 'model citizens'. This is a good example of the complex relationship between political ideology, government strategy, research and service delivery. (see **recovery**)

In its work SDF does not use the phrase 'better than well' as it is wholly misleading in the contexts in which it is often used. SDF challenges the use and validity of this term when appropriate.



Explore further:

Hibbert, L. and Best, D. (2011) Assessing Recovery and Functioning in Former Problem Drinkers at Different Stages of Their Recovery Journeys Drug and Alcohol Review

Collins, A. and McCamley, A. 2018. Quality of life and better than well Drugs and Alcohol Today May 2018

The 'British system'

This term is not contested but awareness and understanding of the British System is very limited and yet it is a very useful perspective from which to view some treatment, for example, heroin assisted treatment (see heroin assisted treatment) rather than imagining, as seems to be the thrust of much media and political discussion, that such approaches are 'foreign' or 'work abroad but couldn't work here'. The British System also contextualises substitution treatment (see **medication assisted treatment**) including methadone-based treatment which are sometimes regarded as imported from the US or elsewhere within a long traditional of British medical practice.

The term 'British System' refers to the treatment system in the UK that evolved from the recommendations of the report of the Rolleston Committee (1926) which was established by the UK Health Secretary John Wheatley MP in 1924. This held that people who had, for whatever reason, developed a dependency on a drug should be prescribed that drug or the nearest pharmaceutical equivalent. The system lasted well into the 1960s and prevented the development of a street drug market like the one that developed in the face of stricter prohibition and unsympathetic medical practice elsewhere, for example, in the USA.

The system effectively controlled the drug market and supported people with dependency well into the 1960s. The system failed largely due to the poor practice or malpractice of a small number of prescribers including Isabella Frankau and Dr John Petro which created a small illegal market. This resulted in media and then public concern and backlash from the UK Government. Government action to further control prescribing dissuaded doctors from prescribing to people who were dependent. This comparatively small group of dependent users were then forced into the illegal drug market then created by criminals and organised crime.

The very last remnant of the British system was the practice on Merseyside led by Dr John Marks from 1982 to 1995 which was eventually closed through local police and political action.

The British System is sometimes used to explain the role and benefits to individuals and wider society of prescribing substitute medication (see **medically assisted treatment**; see **heroin assisted treatment**; see **opiate substitute treatment**).

In its work, SDF uses the example of the British System as a means to view and understand developments in service design and delivery including substitute prescribing as well as explaining the relationship between drug-related harms, supply and drug control.



Explore further:

Sneddon, T (2020) '*Prescribing heroin: John Marks, the Merseyside clinics, and lessons from history*' International Journal of Drug Policy Volume 78

'Chaotic lifestyles'

This is a general term to describe the often complicated and challenging lives of people who have a substance use problem (and/or other significant issues like for example, street homelessness).

Such lives can be very challenging, involve a lot of complex engagements and relationships with peers, family and services and can be unpredictable in the sense that unscheduled events can occur that impact on routines etc. They may appear to outsiders as unmanaged, unmanageable or chaotic.

However, the term is contested and is viewed by some as unhelpful. Describing such lives as chaotic may be unhelpful if it is inferred that they are not or cannot be managed to any degree. People in these situations have often developed a range of skills and means to ensure they can control their life and survive. It demeans people and their efforts to manage their day to day lives to describe them as chaotic. It is unhelpful to suggest that they cannot control aspects of their lives or that they cannot be supported by others in doing this.

It may also be felt that the term is inaccurate as the routine of seeking and getting drugs and then using them is, for some, all-too predictable and part of a long-standing daily routine. If the term is used to 'other' people then it may contribute to the stigmatisation of people who are already marginalised.

There is the potential for poor service design and delivery in viewing people's lives as chaotic. (see '**hard to reach**').

In its work, SDF avoids use of this term and challenges its use when appropriate. Instead SDF may, depending on the circumstance, use terms like:

- challenging lives
- difficult lives
- complex daily routine



Chemsex

The link between the use of substances and sexual behaviour is close and complex and extends back long into human history. The term chemsex was first used to describe very particular circumstances – the use of drugs, sometimes specifically methamphetamine and or mephedrone, and sometimes specifically injecting these drugs, by men who have sex with men and specifically in contexts where sex involves multiple partners.

From these origins, the term came to be used to describe the use of stimulant or other drugs more generally in this context or in the context of men having sex with a single partner especially using ‘hook up’ apps like Grindr.

The term is useful in describing the close association between sexual behaviours substance use and associated risk and the close relationship between these for some people. In working with people involved, the term ‘sober sex’ emerged as a way to describe sex that did not involve the use of substances.

The term is not generally contested. However there is awareness that the term could be applied to any situation where a person is involved in sexual activity while using any substance. Such a broadening of the definition may be unhelpful and it may be necessary to define what experience and behaviour is being referred to when using this term.

There is also awareness that it may appear that people other than men who have sex with men are not engaged in sex, possibly involving multiple partners and substance use – which is, of course, untrue and in moralising discourses may stigmatise men who have sex with men. There are therefore potential ambiguities in its use.

Where people report dependency it seems to be on chemsex rather than the substances they are using. Thus, if it is regarded as a problem chemsex is regarded as a sexual and relationship problem rather than a substance problem. In terms of treatment and support, in practice, focus seems to have settled on relationships and sex rather than on substances. There is an obvious and significant role for harm reduction also. It is possible that, in developing drug treatment services which were more generally lgbt+ ‘friendly’ or focussed, the perception of chemsex and how people might be supported may change.

The term is most effectively used when the intended meaning is made clear and then the term chemsex becomes a shorthand for this particular definition in the context.

In its work, SDF uses the term chemsex but will usually make clear what substances and sexual behaviours are involved depending on the context.



'Clean'

Being 'clean' refers to not using drugs and may be synonymous with abstinence. The definition of 'clean' is disputed in the same way as abstinence (see **abstinence**).

Clean is also a contested term because people may infer that people who are not 'clean' are somehow 'soiled' or 'dirty' and therefore the term may stigmatise people who use substances or have a substance problem.

For some people, the term clean is so contested that it is viewed as stigmatising in all situations. The term 'clean needle' is therefore viewed as stigmatising people who in certain circumstances are forced to use unsterile injecting equipment. The preferred terms are therefore sterile and unsterile injecting equipment.

Some people in abstinent recovery refer to their 'clean time' i.e. the length of time they have not used substances. For some people there is a great sense of achievement in this and 'clean time' is, for some people, a positive feature of having an identity as a 'person in recovery'. Concern has been expressed that this creates hierarchies within recovery communities that, like all hierarchies, may be disempowering and unhelpful to some people. For others, this hierarchy means that people can seek and get support from people who have more experience in their recovery.

In its work SDF, does not use the term clean as there is concern that its use can cause stigma. Of course, if an individual wants to describe themselves as clean and finds it empowering to do so SDF would not challenge their right to do so. If it is necessary to indicate that someone regards and describes themselves as 'clean' the term would be used in quotes.



Instead of 'clean' SDF may, depending on the circumstance, use terms like:

- abstinent
- abstinence

usually explicitly stating the substances from which a person is abstinent e.g. 'abstinence from illegal drugs' or 'abstinence from opiates.' (See abstinence)

In its work SDF does not refer to 'clean' 'unclean' or 'dirty' injecting equipment

Instead SDF uses the terms:

- sterile injecting equipment
- unsterile or non-sterile injecting equipment

'Could happen to anyone'

It is sometimes claimed that a substance use problem 'could happen to anyone'. There is a view that this is de-stigmatising because it challenges notions and moralising views that problem substance use is a consequence of a personal flaw or weakness or that it is a lifestyle choice or a moral failing, a self-indulgence or a sign of delinquency (see **lifestyle choice**). In this sense, there may be consensus that this is positive and useful way to view the prevalence of problem substance use across communities. And yet analysis of available data suggests that problem drug use does not happen to just anyone and there are clear predictors of problem substance use.

Problem drug use is linked to poverty. Similarly, problem alcohol use is linked to poverty. (See **poverty**)

Problem substance is also linked to trauma and adversity in childhood. People who experience trauma or adverse experiences in childhood are more likely to have a substance use problem in adulthood compared with people who have not experienced childhood trauma (see **Adverse Childhood Experiences**). And similar evidence links problem substance use to trauma in adulthood and to mental health problems including PTSD. (See **trauma**; see **self-medicating**)

It may be better to imagine that a substance use problem could happen to anyone; but it doesn't. For a large majority of people, it links to living in poverty; having had adverse experiences in childhood; being traumatised and having a mental health problem. In light of this, substance use may be thought of as a means of coping with extreme life experiences even when this coping mechanism itself becomes problematic. (See **self-medicating**; see **Rat Park**).

In its work, SDF promotes awareness and understanding of the root causes of problem substance use using the clear evidence available that establishes links to poverty and deprivation, adverse childhood experiences, trauma and mental health.



Dependency (and withdrawal)

The use of some substances can lead to dependency. This is a complex process and personal experience and may involve both physical and psychological elements.

It is worth noting that there is evidence that dependency is influenced by the drug itself but more so by the mental state, attitude and beliefs of the person involved and the social and physical setting they are in. (See **drug set and setting**; see **Rat Park**)

People can remain dependent on a substance for the rest of their lives – as is fairly common, in the case of caffeine and tobacco users, for example and people on some medications. Breaking a dependency can involve repeated attempts of avoiding relapse during and after physical and psychological withdrawal symptoms which can be very unpleasant and in the case of some substances, like alcohol for example, life threatening.

Dependency is a useful and objective way of explaining the nature and experience of problem drug use. However, in creating the notion that there are hierarchies of different types of dependence – physical and psychological - it can misdescribe the experiences of people with a substance problem and lead to stigma and misunderstandings that disempower people.

The term dependency can narrowly refer to a person's need to use a substance so that they can prevent symptoms of withdrawal. Withdrawal from some substances can be measured and viewed objectively by observing physical manifestations – pulse rate, vomiting, sweating, cramps, tremors and behaviours such as restlessness, inability to sleep and mental states like fixations including cravings, anxiety or low mood or suicidal ideation. Most people report that their dependency has physical and psychological aspects.

Beyond this narrow definition there are looser definitions – people who are dependent on substances will often speak about using substances to 'feel normal' or to 'be able to function' (see **self-medicating**).

In some discourses – medical discourse but also in media and political and public discourses - a strict distinction is sometimes made between physical dependence – those withdrawal symptoms that are observable by a doctor, for example, and psychological dependence – those which a person with a dependency reports, for example.

Unnecessary dispute is caused by the view that physical dependency is more serious than psychological dependency. This view is hard to justify except perhaps in the case of dependency on substances like alcohol where withdrawal requires medical supervision and can be fatal. But this is a very short term situation. People dependent on alcohol may experience psychological aspects to their withdrawal long after the physical danger of physical withdrawal has passed.

People with psychological dependences are sometimes portrayed as weak or inferior or lacking resolve when compared to people who have a physical dependency. Such notions are ill-founded and are disempowering and stigmatising. They are also unhelpful in supporting people who have a substance problem.

Some substances may readily create physical dependence in people than other substances

however, the social and psychological circumstances of the person involved are highly significant. (See **addictive**).

Another issue is the description of withdrawal symptoms. Some medical and other discourse dismissively describes withdrawal symptoms; for example, in describing withdrawal from opiate dependence as 'like a flu'. This is to underestimate the subjective element in this which is only partially understood. People with a dependence widely report that withdrawal can be deeply unpleasant. The subjective perception of pain and discomfort is very real to the person who experiences it. It may be that physical pain and discomfort can seem intolerable or deeply unpleasant for someone who has regularly used opiates that affect the perception of pain for a long time.

On the other hand, for some people similar withdrawal may be less problematic. This is likely to do with the personal and social circumstances in which people experience withdrawal (see **drug set and setting**; see **Vietnam Veteran Studies**). There is a common misunderstanding that fear of withdrawal or the unpleasant nature of withdrawal is the significant reason for people continuing to use substances or that, consequently, anything that can ease symptoms of withdrawal is a 'cure'. This is based on a misunderstanding of the drivers of problem substance use (see **poverty**; see **self-medicating**; see **adverse childhood experience**; see **trauma**; see **Rat Park**).

In terms of wider political discourse, the term dependency is used in a disparaging manner analogous to its use in drugs discourse – terms such as 'welfare dependency' – are used in ideological opposition to social security, for example.

In its work, SDF uses this term and promotes awareness and understanding of dependency as it can help explain the experience and behaviour of people who have a substance problem. In doing so, SDF challenges misunderstandings of this key concept.



The disease model

The notion that there is a disease called addiction or alcoholism is contested. This idea can help explain people's experiences and behaviours and even be empowering for people with a substance use problem (see **addict**; see **addiction**; see **alcoholic**; see **alcoholism**). Describing experiences as disease symptoms may help people integrate apparently unconnected, difficult and troubling experiences into a whole and allow people to understand and explain their personal experiences and even move on from them.

However not all evidence leads to a conclusion that people who have a substance dependency have a chronic relapsing condition. In fact there is long-standing evidence that this is not the case – or certainly not the whole story. This evidence suggests that problem substance use occurs where there are substances available and few other opportunities or resource (see **Rat Park**) and where substance use helps deal with trauma and there are not other supports available through family or others and through a supportive daily routine like, for example, a home and regular work (see **drug set and setting**; see **Vietnam veteran studies**).

The disease model is often challenged as disempowering for people who have a substance use problem and unnecessarily burdening them with a diagnosis for something that actually may otherwise come to have little or no significance in their future lives.

The disease model is sometimes challenged by people who want to diminish or eliminate the role of medical professionals in treatment. Confusingly, often the same people who make this challenge describe themselves or others as 'addicts' – which is a medical term – for someone with the 'disease' of 'addiction' (see **addict** and **addiction**).

In its work, of course, SDF respects people's right to understand their own personal experiences in a way that is helpful to them in supporting their own progress.



In its work, SDF rarely explicitly talks about the disease model as it is divisive, and the issues are commonly misunderstood. However, when appropriate, SDF points out the ambiguity in the evidence for the disease model especially when the model can lead to negative effects for people with a substance use problem.



Explore further:

Gabor Mate: Drugs, Set and Setting, International Drug Policy Reform Conference 2011

www.youtube.com/watch?v=MNatUMUAmxg

Drug abuse or drug misuse

These terms are used widely to refer to drug use and are contested.

The terms abuse and misuse are contested being regarded by some people as judgemental, moralistic and inaccurate.

They may be regarded as inaccurate or stigmatising as people using drugs are not using the product for a purpose for which it was not designed. They are not abusing or misusing the drugs. An exception may be claimed if people are using pharmaceuticals in ways that goes against advice from the supplier – i.e. a prescriber as opposed to a dealer. However, objection is given to this form of use – for example the abuse of prescribed medicines on the grounds that it is stigmatising and focusses on the behaviour rather than the cause (see **alcohol abuse or alcohol misuse**).

These terms may be regarded as derogatory or stigmatising to people with substance problem as it promotes the idea that that kind of use is wholly distinct from other people's use of the same substance which is not always the case.

In its work, SDF does not use these terms but may, depending on the circumstance, use terms like:

- drug use
- problem drug use.



Drug use can describe any use of any drugs. Where a person's substance use causes risk or harms to them or to other people and they persist in use and if it becomes intensive or compulsive then it is more accurately be referred to as problem substance use.

'Drug free' or 'free from drugs'

The term drug free is used to refer to personal abstinence and has many of the same issues in terms of contentious dispute (see **abstinence**).

This term is also used to describe areas or institutions where there are no drugs present – for example a drug free prison or school or a drug free society. There is an ambiguity here about what substances may be counted as drugs but usually the definition would be illegal drug or illegal drugs and alcohol.

Such drug free spaces are very hard if not impossible to establish as is shown by the failure to create drug free prisons. Even in these most controlled of environments preventing the entry of drugs and their use has not been possible.

It is also argued that creating and enforcing drug free environments would be potentially harmful as it would involve the exclusion of people who used drugs, for whatever reason, and creating such a secure environment that freedoms would be lost and human rights may be violated.

In its work SDF does not use this term to describe people and usually uses this term to describe environments in the context of pointing out the challenge and potential dangers in creating or trying to create such environments.



In terms of describing a person's situation, SDF would use the term abstinent – usually explicitly stating the substances from which a person is abstinent e.g. 'abstinent from illegal drugs' or 'abstinent from stimulants'

Drug of choice or substance of choice

Sometimes people who have or have had a substance use problem themselves or other people refer to a person's 'substance of choice'. This usually is taken to mean the main or usual substance they use for example alcohol or heroin.

It is worth bearing in mind that most substance use including substance use involving a specific 'drug of choice' is a actually polysubstance use (see **poly-substance use**). For this reason there has been dispute over the accuracy of this term. People may not disclose the range of the substances they use because of stigma. People may not realise or recognise the range of substances a person is using for a number of reasons including the stereotyping and stigmatisation of people who use certain substances or have a substance use problem.

This term is also contested in that it implies that a person chose to use substances which throws up issues in a similar way to ideas of drug use and even problem substance use as a lifestyle choice (see **lifestyle choice**).

Lastly there is an issue with this phrase for some people as it may undermine the insight that people use substances as a way of self-medicating for health conditions like pain or anxiety or PTSD, for example. (See **self-medicating**). People who have developed problem substance use sometimes reflect that 'As soon as I tried X I knew it was the drug for me'. Given that people may be in a situation where they are seeking relief from symptoms, is it more accurate to say that the substance chose them rather than vice versa?

In its work SDF avoids using this phrase because it can be unhelpful in obscuring useful insights into the cause and reality of substance use and particularly problem substance use.



Drug-related deaths (DRD)

Drug-related deaths can be a general term for deaths caused by drug use. There are various definitions used. This term may include deliberate and accidental poisonings, suicides involving drugs, overdoses, deaths due to health issues related to drug use and deaths due to accidents or criminal violence caused by people under the influence of drugs. It may even include deaths due to the personal circumstances of someone who uses drugs – death by violence in a situation a person was in because of their drug use – a prison, for example.

In Scotland, annual statistics for drug related deaths are issued annually by the National Records of Scotland. These statistics cover only deaths caused by drug overdose. The figure for 2018 was 1187 – 2% of all deaths in Scotland. The average age of death was 42. The number of deaths caused by drugs using a wider definition may be around double the figure for overdose i.e. over 2000.

In its work, SDF uses this term usually to refer to deaths caused by drug overdose and complying with the definition used by the National Records of Scotland. SDF refers to wider definitions and will explain those definitions in that context.



Drug, set and setting

Some of the most important research work which challenged and continues to challenge popular views of drugs, drug use and people who use drugs has been into the role played by set and setting. While the findings of the research are not contentious the full implications of the findings are still contested – not because of research that contradicts the findings but because of moral and ideological perspectives and alternative models of drug use (see **disease model**).

The argument for the ‘drug set and setting’ model is complex. Its origins are in the cultural changes of the 1960s and it was developed further in the Vietnam Veterans studies published in the 1970s. The idea is best laid out by Norman Zinberg in the 1980s.

In 1966. Timothy Leary, a psychiatrist, carried out experiments on the effects of DMT (dimethyltryptamine) a psychedelic drug, similar to LSD but shorter acting. This had a reputation for inducing intense, unpleasant experiences lasting typically around 30 minutes in both ‘recreational’ and experimental research settings. Leary proved that changing variables other than dose and route of administration, it was possible to support a positive experience in over 90% of his subjects. In a conducive environment – literally a room ‘completely covered, ceiling, walls and floor, by warm, colorful India prints’, for example (see citation below) and with a supportive induction to the experience and the company of people subjects trusted, people reported very positive experience of using the same drug which others had reported in other situations as unpleasant, even terrifying. Leary proposed that this proved that ‘set’

i.e. mindset – the state of mind of someone taking a drug and ‘setting’ the physical and social context in which they use the substance is key to the experience of using the drug. This is the common experience of people who use drugs and particularly the experience of people who use psychedelic drugs in which experiences can greatly differ.

Research by Norman Zinberg of Harvard University, described in his 1984 book *Drug Set and Setting: The Basis For Controlled Intoxicant Use*, challenges the notion of addiction as commonly discussed and described. Zinberg argues that problem drug use is a phenomenon caused not by the inherent characteristics of substances (see **addictive**; see **dependency**) nor by personal weakness or failure of individuals but by the mindset and the social setting of a person at the time that they use drugs.

Heroin use and dependency was common amongst US soldiers in Vietnam by the early 1970s. However, about 88% of the men ‘addicted’ in Vietnam did not relapse to problem heroin use after their return to the US. Zinberg showed that the power of the social setting applied to the controlled use of drugs including heroin and that ‘controlled users’ existed. This suggests that notions of ‘addictive personalities’ and the ‘addictiveness’ of substances are not only simplistic but mistaken.

In its work, SDF promotes and supports the involvement of people who use drugs and people who have had a substance problem as central to understanding drug-related issues in the context of their life experiences and the social situation in which they are or were at the time of their substance use.



Explore further:

Leary, T (1966) *‘Programmed Communication During Experiences with DMT’*
Psychedelic Review VIII 1966

Norman E Zinberg *Drug Set and Setting*
www.youtube.com/watch?v=JgrxLqhcXOo

Gabor Mate: *Drugs, Set and Setting*, International Drug Policy Reform Conference
2011
www.youtube.com/watch?v=MNatUMUAmxg

'Expert by experience'

The notion that people can become experts on an issue through their own personal experience rather than through professional development learning, research, working closely with people who are personally affected by that issue etc. is common in the drugs field.

This empowers people who may not have professional qualifications or experience of working with people affected by drugs but have their own direct personal experience of problem drug use and may have had many peers who have been involved in drug use.

The notion is contested in three ways:

1. What experience gives insight into another person's situation?

For example, does experience of problem alcohol use give a useful insight into the everyday experiences of someone who injects heroin each day?

The answer is complicated. There may be a useful insight into some experiences, for example feeling compelled or needing to use a substance. There may be a shared experience of fear of withdrawal symptoms.

However, there may be less insights in terms of relationships with the police and the criminal justice system or the experience of large numbers of peers suddenly dying of overdose or the stigma that attaches to people who have a heroin problem. Indeed, a person who has had an alcohol problem may hold stigmatising views of someone who has a problem involving heroin. Certainly, there is no shared experience and therefore no insight into the stigma of consuming methadone in a pharmacy; or injecting practice or injecting wounds or perhaps the experience of fear of being tested for, or diagnosed with, viral hepatitis or HIV.

2. Where there is experience, is this the same as expertise?

For example, a person may have injected heroin almost every day for years but does this make that person an expert?

For anyone who has been in this situation or lived or worked closely with someone who has been in this situation, the answer is obviously no. Despite long experience, people often have very poor injecting practice and the rate of injuries and infections, some serious and ultimately leading to ulcers or sepsis or even amputation, is high. And yet good injecting technique and practice is taught to a trainee nurse in a few short training sessions.

3. Is the experience relevant?

Although someone may have experience of, for example, using treatment services, this insight may have a 'shelf life' and months or years later this insight and 'expertise' may have no real use. In fact it may be dangerous for this knowledge to be used to evaluate service provision or to influence changes to service provision (see **user involvement**).

Offence and objections are sometimes raised by professionals within the field who contest that while there is useful insight to be gained from a person's own experience, people without

this personal experience can have the same insight through learning (which may involve conversation with many individuals who are affected by the issue, direct observation of their situation and circumstances as well as book learning and research) combined with human empathy.

It is sometimes contested that the useful shared insight is not that a person's experience makes them an expert but that middle class professionals lack insight into the lives of people who are working class or people who experience poverty. They may not even 'speak their language'. In this case, the 'expert by experience' may have expertise that is less to do with their experience of problem drug use and more to do with their experience and understanding of the culture and background they may share with some other people who have a drug problem (see **poverty**).

Some people who have had personal experience of problem substance use and work within the treatment and support sector may feel that their professional training and qualifications are undermined if they are regarded solely as 'expert by experience' (see **peer workers**).

There is concern also that this term sets people up to fail. People may defer to experience without full engagement and discussion and adequate supports may not be provided to ensure effective engagement. This may lead to tokenism or to bad experiences for people with experience of problem substance use. (See **user involvement**)

In its work, SDF does not generally use the term 'expert by experience' as there is no consensus on the experience required to make someone expert or the expertise that comes from personal experience.



SDF involves people affected by problem substance use in the design, commissioning, management and delivery of services and the development of policy.

SDF is committed to ensuring people with personal experience of substance problem influence service and policy development and are empowered to do so.

SDF works to ensure people using services are empowered to evaluate and involved in improving those and similar services

In its work, SDF does not generally use the term 'expert by experience' as there is no consensus on the experience required to make someone expert or the expertise that comes from personal experience. SDF uses to use clearer terms.

SDF works to ensure awareness of and address the power imbalance that exists between professionals and some people who have insight through their personal experience of substance use and problem substance use.

SDF may, depending on the circumstance, use terms like:

- service user involvement
- involving people who use services
- people with insight through personal experience

'Gateway drug'

This is theory that evolves from a classic misinterpretation of data. Research data shows that the first illegal drug used by people who develop a drug problem is usually cannabis. This was used to create a theory that suggested that cannabis was a 'gateway drug' that led people to more harmful and problematic use of other drugs. Actually, of course, most people who take substances in their childhood or young adulthood initially use alcohol. In terms of first use of illegal drugs, most people use cannabis but the vast majority of people who use cannabis in their youth do not go on to more harmful and problematic use of drugs.

Although the theory is discredited, it still circulates occasionally in media and political discussion of drug issues.

In its work SDF does not use the term gateway drug except to point out the lack of evidence for such a theory. When appropriate SDF will challenge use of this term.



'Giving something back'

This term is used widely in the drugs field. It is used to refer to volunteering and other activity that people who have or have had a substance problem – usually people who may be described as being in recovery- undertake.

People involved in such activity often state that they are 'giving something back'. They may find this term empowering and it may help change their self-image and the impression other people may have of them. It may allow people to feel more at ease with themselves and in their relationship with the wider community or society. People talk about 'worthwhile' or 'meaningful' activity. For some this activity will be therapeutic.

However, there is some discomfort with this term. The notion that people are 'giving back' seems to be analogous to making reparation or repaying a debt or making amends. It seems to re-enforce the idea that people who have a drug problem are somehow taking something away from their community or society and that this should be paid back later.

For some people, this misdescribes at least some people with a drug problem and their relationship with their community or society. For some, the fact that some people have been victims of abuse and neglect sometimes at the hands of the state suggests that they 'owe' nothing to society. The question arises: what is the state or community owed by a person whose parent was imprisoned when they were a child? or someone who was taken into the care of the state as a child and abused and or neglected in that 'care'? What debt does a person have who received a poor education or was themselves imprisoned when they were still a child? What is owed by someone who was refused services and support freely available to others? For someone who has borne stigma and been marginalised by their community for all or most of their life, what debt is now due?

Specific objection has been raised in cases where workers or services have talked about people 'giving something back' or suggesting that people should 'give something back'. This forces on people who have or have had a drug problem the notion that they are in debt and have a duty to make reparation. This is a potentially disempowering, marginalising and stigmatising notion.

In its work, SDF does not use this term while of course accepting that some people engaged in this kind of activity may want to use this term to describe it. When appropriate SDF challenges the use of this term.



SDF may, depending on the circumstance, use terms like:

- meaningful activity
- volunteering / volunteering activity
- structured activity
- employability activity
- therapeutic activity
- work
- job

'Hard to reach' or 'Difficult to reach'

This term is commonly used to describe people who services 'cannot find' or find it difficult to engage in their services.

There is some discomfort with this term.

Firstly, what is meant by 'hard to reach'? Often the people described as hard to reach are very easily found. For example, it is often said that people who are involved in a street homeless scene are 'hard to reach'. Actually, such people are very easy to find – often they are literally on the streets of large cities and in fairly predictable locations. Likewise, people living in very remote rural areas are described as hard to reach but their location is fairly obvious.

The understanding of why people are difficult to engage is also contested. Is this because of some characteristic of this group of people or because of service design? There has been a lot of work describing the characteristics of groups who are hard to reach. Some of this has promoted notions of chaotic lifestyles (see chaotic lifestyle) In the case of racial and ethnic minorities, explanations sometimes include observation on 'cultural issues' that make people hard to reach. It is hard not to conclude that people referred to as 'hard to reach' would be better described as 'difficult to engage' – and that this reflects on the services rather than on the individual concerned.

The most productive work seems to have been in exploring the possibility that service design precludes engagement of some people. Once this is accepted, working with the people excluded by service design to explore this issue and redesign services and service delivery eliminates the 'issue' around identifying, communicating with and engaging people belonging to 'hard to reach' groups. This is a social model of exclusion, analogous to the social model of disability, which holds that exclusion is a product of the design of services and spaces rather than an inherent characteristic of people who are excluded.

In its work SDF avoids using this term and may use a term more like 'people services find it difficult to engage' while emphasising that this is because of a deficiency in service design and delivery.



SDF works to improve service design to address this issue in many ways including involving people who are excluded or under-represented in services in the evaluation of services and in the design, commissioning, management and delivery of services as well as policy development.

Harm reduction

Harm reduction is used to describe a range of measures and supports that aim to reduce the risk and harm associated with substance use. Harm reduction evolved from the practice of people who were using drugs who sought to reduce the harms to themselves and others caused by their drug use. Peer education and peer support have been and are crucial to the development of harm reduction.

Harm reduction measures eventually became embedded in mainstream service provision. Sometimes this was regarded as controversial, despite the considerable and sometimes overwhelming evidence of effectiveness. Evidence for harm reduction interventions has been established from widespread research and is a basis for the further development and implementation of this approach.

There has been sustained controversy around harm reduction approaches since the 1980s when the provision of basic harm reduction services began and was opposed usually on ideological grounds and in ways that stigmatised people with a drug problem and sometimes also those who wanted to support and help them including families and service providers. (See **stigma**; see **pro- and anti-drug**)

Since then, in Scotland, there has been slow but significant progress in the development and delivery of harm reduction measures often in the face of continuing opposition.

Scotland has a good coverage of injecting equipment provision services and extensive, though under-developed, opiate substitution treatment services which were first developed in response to the HIV outbreaks of the 1980s. However the quality of these services and their integration with other mainstream services is affected by the perception of them as 'controversial' or 'peripheral' and the stigmatising of people in who use drugs, people who have a drug problem and people who use drug services. (See **stigma**)

More recently, Scotland has developed a national take-home naloxone programme in response to the high rate of opiate overdose deaths. However, Scotland still lacks drug consumption rooms and drug checking services. The development and provision of drug-related information with a harm reduction perspective is still stymied by the notion that this is controversial (see **pro and anti-drugs**).

Harm reduction is sometimes portrayed as promoting drug use. Given the evidence for the social and personal roots of problem drug use (see **poverty**; see **self-medicating**; see **adverse childhood experiences**; see **trauma**) the issue does not lie in the provision of harm reduction services and this approach. In Scotland harm reduction focus largely on people whose drug use is linked to a range of issues they face and sometimes an overwhelming experience.

A harm reduction approach does not 'normalise' substance use but normalises society's response to a potentially hazardous activity in that harm reduction is how we approach all other behaviours – driving, cycling, participating in dangerous sports – taking an informed decision to minimise risk and avoid possible harms.

Harm reduction is sometimes regarded as 'lacking ambition'. Harm reduction measures can

eliminate harm and risk or significantly reduce harm and risk. This is sometimes downplayed or disparaged as an aim or an achievement. It can be uncomfortable for some people to consider that drug use may cause no or little harm and yet, of course, non-problem use is the norm.

Harm reduction is sometimes portrayed as countering or opposing recovery or abstinence. However, people who regard themselves as being in recovery have often used harm reduction services and practiced harm reduction. The harms they may have experienced as a consequence of their use of substances have been reduced or eliminated. Therefore, the range and extent of the harms they have to recover from is reduced. Also, their ambitions and what they aspire to 'recover to' are not limited by harms they experienced during their problem substance use. And of course, the ultimate harm is death and people need to survive a period of problem substance use to move on and make progress in their lives. An argument that sets harm reduction and recovery in opposition is difficult to sustain. It is worth noting how much of the development of harm reduction involves input from people with personal experience of problem substance use including people who regard themselves as in recovery.

In its work, SDF advocates evidence-based interventions including harm reduction and works to establish, promote and celebrate good practice in this area.



SDF actively challenges the denigration and undermining of harm reduction approaches in its promotion of evidence-based practice.

Heroin assisted treatment (HAT)

This term is used for the prescription of a pharmaceutical drug, diamorphine, to people who have a drug problem involving opiates or opioids, usually heroin (see **opiate substitution therapy**). This practice is one of the oldest treatments for opiate dependency (see **British system**).

Objection has been raised to this term as it may confuse people who regard heroin as, necessarily, a street drug. In fact, of course, heroin is a discontinued trade name used by the German pharmaceutical firm Friedrich Bayer & Co from 1898. One way of addressing this would be to refer to HAT as 'diamorphine assisted treatment'.

There has also been confusion between heroin assisted treatment and a drug consumption room. This was unhelpful in the context of the proposal for both services to be delivered from the same premises in Glasgow. Media and some stakeholder professionals became confused about the distinction between the two services and their legal status.

In its work, SDF uses this term as it seems to be generally understood. However, in working with those involved in media and political discourse and with people working outwith the drugs field, SDF has worked to ensure there is not confusion about this treatment and between services providing HAT and a drug consumption room.



Image and performance enhancing drugs (IPEDs)

This term is widely used for all substances that could be so described – steroids, hormones, cognitive enhancers, botox, tanning agents etc. In some cases, some groups of substances are excluded. This is usually in work that focusses on steroid use and the use of drugs that support a steroid regime – hormones and ‘fat burners’, for example.

There may be discomfort around the notion that these drugs necessarily enhance performance. Even drugs that do enhance performance in one area, for example weightlifting, may negatively affect performance in other areas, for example sexual performance.

There may be discomfort around the notion that these drugs necessarily enhance image and that this term simply may contribute to or support a person’s dysmorphic self-image and notions of images to which people should aspire.

Also, there may be discomfort around the notion that all of these substances are usefully described as drugs. Within the drug field, the term usually applies to psychoactive substances only and these are not (all) psychoactive substances.

Some people using some of these substances, for example tanning agents, may regard these as beauty products and may be alienated by reference to these substances as drugs.

In its work, SDF uses this term and if necessary, makes clear which substances or groups of substances are being referred to.



Injecting equipment provision (IEP)

This term is used in Scotland to refer to services that elsewhere are called by a variety of names including needle and syringe services or needle exchange services.

These are harm reduction services for people who inject drugs and are designed to reduce the risk of infection including infection with blood-borne viruses (chiefly viral hepatitis and HIV) and also bacterial infections. In Scotland foil is provided to support the transition to smoking rather than injecting drugs or to prevent the transition to injecting in the first place.

Engagement with an IEP service may also be an opportunity to receive information and advice and to be signposted to other services.

IEP services originally developed to work with people injecting opiate drugs like heroin – and later and to a lesser extent people who injected stimulants like cocaine. More recently, IPED users have been encouraged to use IEP services and specialist services and products have been developed for this purpose. (See **Image and Performance Enhancing Drugs**).

There is nothing contested about the term injecting equipment provision and there is a consensus that it is an improvement on needle exchange which may give the impression that returning old equipment is a condition of getting new injecting equipment and overly focusses on needles rather than the range of paraphernalia available.

However, the term injecting equipment provision does not really cover the provision of foil and so the term is slightly inaccurate and may become outdated.

In its work, SDF uses this term and prefers it to other terms used elsewhere. SDF supports the expansion and support of IEP services. SDF promotes best practice and the development of IEP services in Scotland. For SDF this involves a range of activity including hosting and facilitating the Scottish Needle Exchange Workers Forum.



Journey metaphors

Journey metaphors are often used in the drugs field to explain people's own personal experience of drug use and problem drug use, to explain the role of services and other interventions and to describe experiences defining or contributing to recovery. Journey metaphors are particularly common in recovery discourse (The Road To Recovery, for example) and in mutual support and other settings where people share their experiences of problem substance use and recovery. (see personal narratives)

A journey metaphor may include a starting point, a route of some kind and a destination. However, this common method of relating complex narratives has significant issues because

such metaphors are simplifications and incomplete accounts of a person's experience.

- At what point does the journey begin?
- At what point on that journey does a person 'have a drug problem' and at what point are they 'in recovery'?
- Does that journey have a fixed path or a fixed destination?
- What does it mean if a person's 'journey' stalls or they take a 'backward path'?
- Does the journey ever end?
- Is the person still on a journey? and, if so, will their perspective on their experiences change again in the future?
- At what point did the person begin to think of these experiences as a 'journey'?
- Are a person's own experiences being described and explained by other people using a journey metaphor?

Journey metaphors are useful but there are significant issues. They can obscure the complexity of what actually happened to people. They may imply that there is a simple process in moving from problem substance use to recovery which is not necessarily the case. By focussing on the individual, they can remove the societal, community and family aspects of people's experiences both in terms of the root cause of problems and how they are addressed or resolved. (see **personal narratives**).

In its work, SDF uses journey metaphors but is keen that they do not misrepresent or lead to misunderstanding about the reality of people's experiences. To avoid this SDF sometimes challenges over-simplification or omissions in narratives when it is appropriate to do so.



J****e / J****y or The 'J' word

A term for a person with a substance use problem – usually an opiate-based substance use problem and usually a person who injects drugs. Various explanations having been given for its roots in 1920s American slang. Not all of these are explicitly derogatory; for example, there is a theory that the term stems from the fact that people with an opiate problem used to collect and sell scrap metal i.e. junk. Another theory, obviously racist in origin, is that they used heroin that was imported by Chinese people – and the term originally was a term for people who were Chinese (i.e. someone who sails in a junk).

More obviously, the term is simply derogatory and a synonym for trash or rubbish. Whatever its origin, the term was popularised in the sixties partly by William Burroughs' autobiographical novel originally published in 1953.

In current usage, the term is almost always derogatory and offensive or at least dismissive. While some people who have or have experience of problem drug use may refer to themselves in such terms, for others to do so is commonly regarded as offensive and stigmatising.

The term is now popularly applied to people involved in all kinds of behaviour and not only drug use (see **addiction**).

The term is still used in the print media usually to refer to an individual who has drug problem who has also been accused or convicted of a crime sometimes completely unrelated to their use of substances. In these circumstances it deliberately stigmatises the individual and also stigmatises people who have a drug problem and people who use drugs.

In its work, SDF does not use this term and actively discourages its use in any setting and actively challenges its use when appropriate.



'Just say no'

Just Say No was a campaign promoted and fronted over several years in the 1980s by then US First Lady Nancy Reagan. The campaign focussed on children and young people and was meant to educate them about the dangers of drug use and promote skills to refuse an offer of drugs. The phrase Just Say No became popular and was used simply as an anti-drug slogan. There was widespread adoption of the phrase and it was used in campaigns independent of the Reagan initiative. This was intentional.

There is no evidence the campaign was effective in reducing experimental substance use in children and young people. A 2009 meta-analysis of twenty controlled studies revealed that young people involved in DARE, a Just Say No programme, were just as likely to use drugs as were those who received no intervention and more likely to use alcohol or tobacco products.

Besides being ineffective, the campaign is open to a range of criticisms – including that it was actively harmful.

The perception that all children are being offered drugs particularly in school settings was, at that time and still, not accurate and arguably unhelpful in demonising and misdescribing people who are involved in drug supply (often, themselves, school pupils) and children who use drugs.

The exclusion of mention of tobacco and alcohol, the substances most commonly used in this group and most harmful to this group, seems perverse and sustains misunderstanding about the nature of substance use and the risk involved.

The 'just say no' message perhaps led to a belief that people who used drugs and people who developed a drug problem did so because they had 'just said yes'. This perception leads to a misunderstanding of the causes of problem drug use and to stigma (see **lifestyle choice**). An argument that people who developed a drug problem are simply people who 'just said yes' is difficult to sustain and unhelpful.

In treating all substance use as something to be avoided, the campaign closes down discussion about risk, harm and harm reduction and so may be framed as an anti-education campaign. People do not emerge from such campaigns more knowledgeable but arguably less knowledgeable.

The fact that Just Say No's emphasis on harm contradicted the personal experience of young people who had used drugs and had (at least some) positive experience or had experienced nothing that they perceived as harm, meant that the whole message was rejected by the very young people who might otherwise have been prioritised as a target audience for drugs education – i.e. young people who use drugs. It is arguable that this undermined all subsequent attempts to engage and educate this group of potentially vulnerable people about issues around drug use.

All of these criticisms can be made of the subsequent UK based campaign that influenced schools-based drug education for decades even after the Just Say No slogan became tired and disused.

In its work, SDF does not use this term. SDF works to promote evidence-based drugs education and points out the potential harms in other approaches when appropriate including the evidence against the promotion of 'just say no' and 'lived experience' testimony in work with young people.



Explore further:

Warren, F. *'What works' in drugs education and prevention?* Scottish Government 2016

Wei Pan & Haiyan Bai (2009) *A Multivariate Approach to a Meta-Analytic Review of the Effectiveness of the D.A.R.E. Program* International Journal Environmental Research and Public Health. pp 267–277.

'Lifestyle choices'

Substance use and even problem substance use are sometimes referred to as lifestyle choices, usually in the context of political or media discussion. The implication is that people make a free choice to use substances and some develop problems and choose to continue to use. This is usually used to leave responsibility for problem drug use solely with the individual and, crucially to diminish or remove any responsibility the state or other stakeholders have to support and assist the person.

This view can be regarded as simplistic and damaging. The vast majority of adults use psychoactive substances of some kind and the use of such substances is a common feature across all human history and culture (see **abstinence**).

The notion of problem substance use as a lifestyle choice or as a lifestyle choice 'gone wrong' also denies the extensive evidence that problem substance use is closely associated to varying degrees with poverty, adverse childhood experiences and trauma. (See **poverty**; see **adverse childhood experiences**; see **trauma**). It denies the science of public health that individuals have limited control over their lives and health behaviours.

Objection may be raised also if people are regarded as self-soothing or self-medicating by using substances or using substances as a coping mechanism for aspects of a life that people find otherwise intolerable (see **self-medicating**). To what extent is there a choice, particularly if there is limited or no access to other means to achieve these ends?

Objection may also be raised on the grounds that some people have a physical or psychological dependency on a substance and require to use substances to prevent unpleasant and perhaps dangerous, even fatal, withdrawal or to 'remain normal' or 'feel normal'.

Objection may also be raised as this term suggests that people have a range of options while in reality there may be very few or no attractive 'lifestyles' available. And if options are available then how free a choice is a person making in the face of other pressures?

In its work, SDF does not refer to drug use or problem drug use as a lifestyle choice and when appropriate challenges the notion that problem drug use is a lifestyle choice.



Lived experience

This term is rooted in phenomenological research in which lived experiences are the main object of study. The aim of such research is not to understand individuals' lived experiences as facts, but to determine the meaning of these experiences. This is very different from the way the term is now commonly used in the drugs field in Scotland.

This term is currently used to describe both people who have used and / or who currently use drugs (or specifically have or have had a drug problem) and to the experiences people have had in this context. It usually refers to people who have had a substance use problem and sometimes includes people who currently have a substance use problem.

There are objections to this term as it may differentiate people who have had a substance use problem from those who currently have a problem and re-enforce a perceived hierarchy between these two groups. At times though this may be useful where the perspectives and experience of these two groups are different. The term 'living experience' is sometimes used to describe people who currently have a substance use problem.

'Lived experience' is usually used in a context of advocating the inclusion of people with lived experience in:

- the planning, design, commissioning, management and / or delivery of services which work with people who use drugs or people with a drug problem (see **user involvement**)
- the development of policy or strategy on issues affecting people who use drugs or people with a drug problem (see **user involvement**)
- the education in drug-related matters of the public, or the particular groups, for example, young people in schools, people working in services

There is some ambiguity and contention around the term.

Who is included? Are people who have an active and current drug problem included? If not, why not? How can they be supported to be included in processes that are not tokenistic (see **user involvement**).

Do **all** people with lived experience have a useful insight into **all** drug use or problem drug use and **all** related issues?

Does lived experience have a 'shelf-life'? – is experience from years ago still relevant or offer insight today? (See **personal narratives**)

Because lived experience has come to be used as a blanket term for all personal experience of problem substance use, it may de-personalise people and deny them their individuality and the unique aspects of their experience and opinion. In such a wide group of people there will be a whole range of experiences, opinions, perspectives and prejudices.

Processes to 'involve lived experience' face significant challenges including addressing power imbalances and creating acceptable and accessible settings and contexts for this work to be undertaken (see **user involvement**; see **personal narratives**).

In its work, SDF sometimes uses the term 'lived experience'. When it is used it requires further clarification of exactly which people are being referred to – what experience they have had and when this experience occurred and what perspective they may have on this experience. SDF encourages others to be clear in these matters. They are almost always significant.



SDF more usually uses the term 'personal experience' as in 'personal experience of a drug problem' or 'personal experience of using treatment services' and 'people with personal experience'.

SDF would always want to ensure the inclusion of people with personal experience of an active and current drug problem and people currently using relevant services; advocates for systems of work that support this inclusion and advocates and ensures that any necessary additional supports are in place to ensure this.

Medication-assisted treatment or Medically-assisted treatment (MAT)

This term is used to describe substitution treatments, including opiate substitution and stimulant substitution for example.

The term is becoming more commonly used in Scotland partly because it was adopted by the Drug Death Task Force in 2019.

The term is not widely contested. However, there is an ambiguity in regard to the element of treatment that is not medication. Is this always required and on occasion, when nothing else is delivered except medication, what issues arise?

The provision of substitution medication alone can greatly improve a person's social and health status. It can transform a person's life and the lives of people close to them (see **OST**). In this case to describe the intervention as harm reduction may seem an inadequate description (see **harm reduction**).

However, when the person still has very obvious challenges in terms of mental and physical health and in their social conditions – housing, employment, access to their children and family support, for example, there remains a sense that their 'treatment' is incomplete (see **treatment**).

SDF works to improve treatment and support services and advocates evidence-based practice and a person-centred approach which focusses on people's needs and desires and supports and empowers people to identify and address the issues they face and make progress as they define it and as it develops.



In its work SDF uses this term and also uses, when appropriate, other terms:

- opiate substitution treatment or opiate substitution therapy (OST)
- opiate replacement treatment or opiate replacement therapy (ORT)
- opiate agonist treatment (OAT)

Opiate substitution treatment/opiate substitution therapy (OST)

or

Opiate replacement treatment/opiate replacement therapy (ORT)

or

Opiate agonist treatment (OAT)

There are various terms for prescribing a pharmaceutical equivalent for people who have a drug problem involving opiate street drugs. An internet search suggests OST, standing for Opiate Substitution Therapy is the term most commonly used in Scotland.

In the UK, this practice links all the way back to, at least, the establishment of the British system (see **british system**) that emerged from the report of the Rolleston committee in 1926. The evidence for prescribing methadone goes back to the early 1960s and is extensive; methadone being one of the most widely researched medicines and OST one of the most widely researched treatments in medical history. OST with either methadone or buprenorphine is the World Health Organisation's (WHO) recommended treatment for opiate dependence and methadone is on the WHO List of Essential Medicines.

All of this has not prevented OST and methadone prescribing being the subject of a controversy in Scotland which is now entering its fifth decade. Much of this controversy is unnecessary in that it involves assertions for which there is little or no evidence or the generalisation of particulars which are not accurate or typical (see **parked on methadone**). Sometimes this controversy is based in misunderstanding on the role of treatment (see **treatment**). For some, the controversy is rooted in fundamentally ideological and moral positions on the respective roles of the individual, the family, community, wider society and the state in the causes and means to address problem drug use.

This controversy has impacted on Scotland's ability and capacity to prevent and address problem drug use and on the quality of treatment and support services. For these reasons, the fact that there is a controversy, rather than the detail of that controversy, is an issue in itself. It

is an issue which has stigmatised the best evidenced clinical intervention to support people with an opiate-based drug problem i.e. OST and methadone specifically (see **stigma**). It is an issue which results in human suffering and preventable deaths.

In its work, SDF uses all of these terms but most commonly uses OST.



Optimal dosing

Most medications have recommended doses which will ensure that the medicine can be effective and used safely with minimum side effects. In the case of OST medications there are recommended optimal doses. However, this area has become contentious and drawn into a wider controversy around OST and specifically methadone prescribing (see **OST**).

The purpose of OST is to stop someone having to use street opiates because they are in withdrawal. One benefit of substitution with methadone is that methadone lasts at least 24 hours and so it can be consumed once a day and the person is then free to build a daily routine around other activity and not around avoiding withdrawal, seeking drugs and consuming drugs. To achieve this, a person must be on a dose that prevents any withdrawal symptoms for over 24 hours. For them this is a minimum optimal dose.

People have different optimal doses due to tolerance and how well their body metabolises substances (see **tolerance**). Unfortunately, a focus on the comparative size of doses has made this controversial in some instances. People who have been on suboptimal doses can view an increase in dose as a step back in their progress; people on higher doses than other people (because they experience withdrawal at a different dose) can view themselves as 'more addicted' than others. People in these situations need support and good quality information about their medication and may benefit from a wider conversation about the purpose of treatment and the potential role of other forms of substitution – diamorphine, methadone, buprenorphine should all be available – or the potential role of a reducing their prescription and detoxification.

One of the benefits of focussing on achieving an optimal dose that is defined as a dose that prevents any feeling of withdrawal until the next dose is consumed and prevents or greatly reduces 'topping up' with other drugs is that a patient can be experience these situations for themselves. This approach is far more person-centred than a fixation only on the size of the dose or prescribers naming a dose they are prepared to describe. A lot of unnecessary concern arises from a fixation on whether a dose is 'high' or 'low'.

In its work, SDF uses this term and advocates optimal dosing in the context of a person-centred approach and works to ensure that people working to support people with an opiate-based drug problem and people with a drug problem themselves understand the purpose of optimal dosing and other issues in prescribing.



'Parked on methadone'

This phrase is used in the UK media and in political debate on drug issues and also sometimes by people who have a drug problem, people in treatment and people working in treatment and support services.

It is generally used in a way that is dismissive of or denigrates opiate substitution therapy (OST), and methadone in particular (see **opiate substitution treatment**). Interestingly it does not seem to be used with regard to OST that involves buprenorphine. This suggests that the term reflects the stigmatisation of methadone – which while not unique to Scotland is highly developed in Scotland (see **stigma**).

There seem to be two aspects to the use of this term which are distinct and crucially different.

Firstly, a person is described as 'parked on methadone' if they are on methadone for a long time. It is worth noting that in Scotland there are no statistics available about how long people are in continuous treatment. Although people commonly report being on methadone continuously, when this is questioned, many people recount that they have actually been in and out of treatment several times for various reasons including being forced out perhaps through a 'disciplinary discharge' or because of relapse or because they were hospitalised or imprisoned and did not resume treatment on release or discharge or through a choice they made at the time.

Secondly, there is an issue of understanding the nature of OST as a treatment. The evidence is that one of the benefits of being in OST is that it significantly reduces the risk of overdose and fatal overdose. However, this is only the case if a person has been on continuous OST for over a year.

Also, it is important to note that OST is intended as a long-term treatment. The hope is that the person can reduce or eliminate their use of drugs which frees them from having to get money to buy drugs; seeking drugs; consuming drugs. This may help remove their engagement with the police or criminal justice system. It may also help them to move away from a group of drug-using peers and form and re-form relationships with people who do not have a drug problem. This may include family, their children and other relationships. These relationships can support people in making progress. In this more stable and supportive situation, the person may be able to move on to address issues they face and resolve practical issues including housing and debt issues. They may also engage with services supporting them around their physical and mental health better than they were able to when they were using street drugs. Being on

OST may also help people build a daily routine involving meaningful activity including, for example, any care responsibilities, volunteering, learning and training and paid employment. All of this is possible for some people while on a methadone prescription, at an appropriate dose and while adequately supported, if and where necessary.

The term 'parked on methadone' can be used to raise legitimate concern that treatment and other services have not supported a person to make the kind of progress described above when that support is required and may have been requested by the person themselves; when attempts to engage with other supports have been refused, perhaps, because they are on OST. There is a legitimate concern here. There are issues with mainstream services being reluctant or not having the capacity to support people with complex needs and there are stigmatising attitudes and behaviours toward people who have a drug problem and people in treatment, particularly methadone. There are issues also with the quality of treatment services themselves and their capacity to work with people on OST to design and then deliver or ensure delivery of a package of treatment, care and support that meet the needs and desires people have in making progress on a range of issues as illustrated above. All of these criticisms can be applied to various services and there is much improvement that could be made however the issues is with the quality of services and services systems and not the medication which people are prescribed.

The phrase 'parked on methadone' often reflects the stigmatising and prejudiced attitude towards methadone and people who are prescribed methadone. This stigma is deeply unhelpful in that it discourages people from engaging in treatment; it lowers their expectation of treatment services; demotivates them in engaging with wider supports; it may mean families are concerned their family member is even in treatment; it results in more barriers to volunteering, training and other meaningful activity. It contributes to the isolation of treatment services from mainstream services. In other words it contributes to the very issue that the term 'parked on methadone' attempts to describe.

In its work SDF does not use this term as it is stigmatising to people on methadone treatment and because it is ambiguous as to the real nature of the concern expressed by those using it. It also obscures the real and valid criticism that could be made of the treatment and support people receive by focussing on medication rather than treatment services and treatment and support systems available to people.



When appropriate SDF will challenge the use of this term to try and better articulate the concern being raised. SDF is, of course, concerned in improving the quality and capacity of services providing treatment, care and support to people who have a drug problem and people who are prescribed methadone specifically.

Peer workers

In the drugs field people with personal experience of problem substance use have been involved in service development and delivery for decades. Drug treatment services, as developed from the 1960s and particularly in the 1980s and 1990s were often staffed by people with similar personal experience. This was particularly the case in the third sector and in residential services.

In the professionalisation of the field it became less common for people to disclose their status as having personally experienced problem substance use. The drivers for this were that people with their own experience of problem substance use working in the field gained their own professional experience and qualifications and were often promoted and their professional credibility did not solely rest on their personal experience and commitment but also, and perhaps mainly as they saw it, in their work experience and qualifications. Secondly, it was felt that workers who did not have direct personal experience were undermined if workers with such experience established credibility and tried to develop trusting relationships with the people using the service on the basis of disclosing their own personal experience or their identity as a person in recovery. In some services, such disclosure came to be regarded as unprofessional. Although people with their own personal experience were still drawn to work in the field and valued for their contribution as staff in services, their status as people with personal experience was often not explicitly stated.

The emergence of the recovery agenda meant that people with personal experience were sometimes explicitly recruited into post for which such experience was required and also, more commonly, 'lived experience' was regarded as a positive in recruitment of people to frontline posts. Again, workers in services began to explicitly state that they had personal experience or shared their identity as someone in recovery. Some people who had worked in services for years and not shared this information, at least with people using the service began to 'come out'.

SDF supports the professionalism and commitment of people with personal experience of problem substance use who work in services and recognises and celebrates their contribution to the drugs field in Scotland. SDF works to support people with personal experience to find employment in the drugs and wider care field, most particularly through the Addiction Worker Training Project.



People-first language

In discussing drug-related issues, it is often useful to identify, describe and discuss groups of people who have aspects of their behaviour or their personal situation, or other characteristics in common. This can support insight and understanding and improve the way people are treated and supported. However, in describing groups of people, the language used can sometimes become very impersonal and this may contribute to depersonalisation, 'othering' and stigma.

One means of addressing this is to use terms like 'people who use drugs' rather than impersonal terms like 'drug users.' This is called people-first language.

The personalisation of language can mean people become more conscious that they are speaking about people rather than in abstractions. This may help reduce and challenge stigma (see **stigma**). Sometimes using people-first language makes people more specific about the group of people they are referring to. For example, general terms like 'drug users' may be replaced with more specific terms like 'people who use cocaine' or 'people who inject drugs' etc.

One problem that arises in the use of people-first language is that terms become longer than other terms. For this reason, acronyms are sometimes deployed; for example, 'people who use drugs' becomes PWUD and PWID is used for 'people who inject drugs'. This is generally accepted in written reports and research papers; however, in spoken language using terms like 'PWUD' or 'PWID' simply defeats the purpose of people-first language which is to ensure the humanity of people within groups is not forgotten. This is regarded as bad practice.

Another issue is that the media are resistant to people-first language as it tends to be more 'long-winded' and less 'punchy' than other language – especially in newspaper headlines.

In its work SDF deploys people-first language and advocates its use to others. SDF uses acronyms to replace people-first language only in formal written contexts e.g. research reports to reduce repetition and improve ease of reading.



SDF works with the media to explain issues around language used to refer to people who use drugs and others; offers practical suggestions as to appropriate use and challenges stigmatising and inaccurate language.

Personal narratives

Personal narrative is a semi-formal verbal or written communication of a person's experiences by the person themselves. The use of personal narratives is common within the drugs field. They are used in therapeutic settings, in peer settings – 'shares' in 12 step fellowship (see **Alcoholics Anonymous**), for example; in training and briefing of expert professionals within the drugs and related fields; they have also been used in preventative work particularly with children and young people.

Personal narratives can be powerful and seem more direct and real to some people than other forms of therapy or learning experiences. However, the role and value of personal narratives is contended.

Personal narratives are deeply embedded in western culture and are the basis for Catholic confession and Protestant declarations of faith. Indeed it is striking how many personal narratives dealing with problem drug use and recovery follow quasi-religious formats. It is not unusual to discern key Christian ideas within personal narratives:

- journey metaphors (the 'path' or the 'road') ('I started out...' 'I ended up') (see **journey metaphors**)
- examples of 'bad' behaviour – sin; sometimes repeated ('I stole anything'; 'I lie to everyone all the time') or sometimes a single exemplary instance - ('I stole from my mother's purse')
- some form of nadir moment (see **rock bottom**) ('I missed my daughter's wedding' 'I was involved in a serious crime and was jailed for 7 years')
- meeting an individual – a messiah ('In prison I met a man who asked me what I wanted in my life')
- or being in a particular situation that induces a sudden insight – revelation ('And then it occurred to me that I was never going to have control over my life as long as drugs had control over me')
- the hard work of personal change and being involved in positive activity - penance ('I have done a lot of work on myself'; 'Now I help others') (see **giving something back**)
- the feeling of well-being and contentment – redemption ('And now I live a useful purposeful life' 'People treat me like I am the same as them')
- gratitude ('Every day I am thankful that I am sober')

The reason for this is simple. People are not relating their experiences completely and direct – that would be impossible. They are relating very complex and sometimes confused and confusing and even troubling and painful experiences in a way that is safe for them and for their audience.

They are telling their story in the hope that in doing so there is a benefit for them and they hope, benefit for their audience. People want to have lives that, on some level, 'make sense' and are 'meaningful'. They want even the most negative or disturbing experiences to have positive aspects and consequences. They want people to understand their experiences. They want to be accepted by other people. So, people soon learn ways to tell the story of their

substance use, their substance use problem and their recovery in a way that achieves these things. This is not to say their story is not true or insincere. In fact, for many people the fact that their story is true and sincere is part of the point of telling their story as they regard this as evidence to themselves and others that they are in recovery or are recovered.

Nevertheless there are huge and crucial omissions in these narratives – often much of the social context is omitted; the complexity of the relationship with services; the ambiguities of motivations and personal relationships are not represented; the extent of mental health issues may not be acknowledged. Importantly the exact details of what the person felt and their attitude, motivations and beliefs at the time these events occurred is often completely absent or mentioned only in passing. This occurs partly because things may not be viewed as relevant, the person may lack insight or for example have had low expectations of services and therefore not really see the insufficiency of the service they were offered etc.

Often people choose to start at the point where they started using substances but what was going on at that time and before this? Are aspects of childhood experience or wider social circumstances not being included in the story? The family and social context is often not explored. (See **adverse childhood experiences**; see **poverty**; see **trauma**; see **self-medicating**)

The use of 'stand up and tell your story' personal narratives takes no account of the power imbalances that exist between the person telling 'their story' and their audience which in some contexts may be composed of professionals and academics, for example. In fact by asking a person to reveal aspects of their life that their audience may not be willing to share – the circumstances of their family or their criminal behaviours, for example - personal narratives often reinforce the power imbalance between the 'narrator; and their audience.

These kinds of limitation exist for all personal narratives and not only personal narrative around problem substance use.

The shortcomings of personal narrative can be overcome by including people with personal experience of problem substance use in ways that avoid the 'stand up and tell your story' format. Discussion and appropriate questioning may be helpful. It may also be helpful to focus on a particular issue rather than an overarching narrative. It would be useful to have more than one person or a small number of people involved. It will always be necessary to address any power imbalance between the person and their audience. (See **user involvement**)

It is worth noting that one sphere in which there is hard evidence about the effectiveness of the use of personal narratives is in the education of young people in school environments. The evidence is that this is not only ineffective in the prevention of drug use but that it is harmful and is no longer recommended in Scotland. And yet there is still pressure for personal narratives to be used in this and other contexts.

SDF acknowledges the potentially therapeutic role of developing and sharing personal narratives.



In its work, SDF supports more engaged involvement of people with personal experience in workforce development, the design, commissioning, management and delivery of services and in the development of policy on issues related to problem drug use and other issues. It discourages the use of personal narratives in these contexts and challenges any approach that 'involves people' solely by using personal narrative.

SDF works with people to develop life narratives that support employability in the Addiction Worker Training Project. This involves supporting people to make positive and appropriate disclosure as part of recruitment processes.



Explore further:

Warren, F. *'What works' in drugs education and prevention?* Scottish Government 2016

Polysubstance use or polydrug use or polypharmacy

This term refers to the use of more than one substance at a time. The term is not contested but the drivers of polysubstance use are often not explained or understood and so people involved in polysubstance use can be stereotyped or stigmatised as 'reckless drug users' or 'hopeless addicts'.

Although polysubstance use is sometimes regarded as if it was something distinct and unusual, many people are involved in polysubstance use – sometimes when not realising it. This can happen even when someone thinks that they are using one substance and then waiting for the effect to pass before using another substance as, although the effect may not be apparent, a substance can still be active within the body, putting strain on the body's systems. This can cause unintentional overdose.

People can also be involved in unplanned polysubstance use if they are forced by circumstances to consume a second drug or more than one drug. This can happen, for example, when they find themselves in possession of drugs and are suddenly stopped by the police or security staff.

Commonly polydrug use also happens when people think they are using one drug but it has become adulterated or has been diluted with another psychoactive substance – this is often the case in the supply of street drugs which is controlled by criminals and completely unregulated.

Polysubstance use is also deliberately practiced to achieve desired effects. However, often the quality of drugs is so poor (they are diluted and so less effective) or the supply is interrupted and there is less available than a person needs and for these reasons a person can end up obtaining and mixing substances that they did not really plan to use.

Some people in a state of intoxication can end up using other substances that they would not have planned to use due to disinhibition – this is particularly true of people using drugs like alcohol which disinhibit people who use them.

So unregulated criminal supply, law enforcement and ignorance of the way the body processes drugs all play their part in polysubstance use.

Polysubstance use is a higher risk activity and there are specific harm reduction measures around this. The vast majority of overdose deaths in Scotland are polysubstance use deaths.

In its work SDF uses these terms frequently and points out the drivers and risk of this type of substance use when appropriate.



Poverty

The link between poverty and problem substance use is clear. This is borne out in statistics but also in the experience of those working with people with substance use problems and in the personal experiences of hundreds of thousands of people in Scotland.

A few statistics paint enough of the picture to confirm the link. In 2017/18, an estimated 49% of the patients with a drug use related GP consultation lived in an area classed as in the 20% most deprived areas as opposed to the 4% of patients who were living in the 20% least deprived areas. Approximately half of the patients with a drug-related general acute or psychiatric hospital stay lived in the most deprived areas in Scotland.

Problem alcohol use is similarly linked to poverty. For example in 2015 in the most deprived areas of Scotland rates of alcohol-related death were six times higher than in the least deprived areas, while rates of alcohol-related hospital stays were nine times higher. (Monitoring and Evaluating Scotland's Alcohol Strategy (MESAS) NHS Health Scotland 2017)

And yet the root cause of poverty is denied in notions of problem substance use being a personal or moral failing or a wilful choice (see **lifestyle choice**). These can be regarded as moralistic arguments which are based on religious perspectives that substance use is essentially sinful i.e. evil. There are also political perspectives that deny the role of poverty and the role of the state in inducing and addressing problem drug use. The evidence clearly contradicts any assertion that poverty and indeed class are not relevant.

There are people who have no experience of poverty but who develop substance use problems – these are largely linked to trauma and mental health issues. (See **adverse childhood**

experiences; see trauma; see self medicating)

It should also be noted that people who experience poverty and have a substance use problem may well also have experienced trauma and mental health issues.

Poverty is a stigmatised state and people do not readily self-identify as being or having been in poverty. Poverty is also closely linked to class which is an issue many people can find it difficult to discuss or describe. For these reasons, poverty is not mentioned in many personal narratives (see personal narratives). It may also be excluded from personal narratives because people feel that they are blaming their community for their personal problems (which the poverty analysis does not do, of course). They may also feel that poverty is irrelevant because a substance use problem 'could happen to anyone' – which is not borne out by the evidence. (See **could happen to anyone**). Poverty is also perhaps excluded from personal narratives because it is taken for granted; a 'given'.

In its work, SDF emphasises the evidence base linking problem substance use to poverty, trauma and mental health. SDF challenges simplistic notions that deny these links individually or collectively.



Of course, SDF accepts that people may describe the cause of their own problem substance use in ways that suits them in their current situation, helps and supports them to be accepted and understood by others or in a way that they find empowering or destigmatising.

'Pro' and 'anti' – drug

Because of a declared 'anti-drug' agenda in some political discourse (see **war on drugs**) a notion has developed that people, organisations or other stakeholders in the drugs field are either pro- or anti- drugs. This is unhelpful and causes unnecessary dispute and division. Framing drug issues in this way limits the capacity to discuss and debate issues and reach compromises and consensus. It is hugely limiting particularly within political and media discourse.

The use of substances can be regarded as normal and as a 'given' as it is present throughout human history and across all human geography (see **abstinence**). It is normal for substances to be used in ways which mean that any risk or harms are personally, socially and culturally acceptable. This is the normal way in which society addresses risk and harms – in the context, for example of the risks and harms from cycling, participation in sport, consuming foodstuffs etc. there may be some regulation and education and otherwise there is personal choice.

Problem substance use develops not from the existence of substances or even the supply of substances but from poverty, trauma, physical and mental health problems. (See **poverty; see trauma; see adverse childhood experiences; see self-medicating**).

There is limited evidence of the promotion of substance use by suppliers, except of course

in the regulated advertising and promotion of legal substances – alcohol and tobacco. Drug dealers do not generally promote or advertise their products they simply find demand. Recently the development of online sales has led to products being described as ‘good’ etc but this ‘promotion’ is crude and ‘amateurish’.

The promotion of drug use is done through peer networks of people who use non-problematically or ‘recreationally’ and through cultures that develop around the use of substances; for example, the ‘rave’ scene and the increase in ecstasy use. Whether such cultures are a significant cause of substance use or merely celebrate substance use may be disputed.

The claim that those who provide or support the provision of harm reduction services are ‘pro-drugs’ actually makes no sense when harm reduction is viewed as the means by which all risk behaviours are addressed within society (see above) and substance use is acknowledged as a universal human activity. Likewise, the notion that people promoting abstinence as a means to address problem drug use are necessarily ‘anti-drug’ is unhelpful.

In its work, SDF does not frame issues within the drug field or wider discourse on drugs as pro- or anti-drugs and challenges this perspective when appropriate.



Problem substance use / Problem drug use

These terms refer to substance use that is ‘problematic’ – which harms the person and others.

The terms are generally used and accepted. Contention has been raised by people who regard all substance use as harmful. They argue that these terms imply that there are forms of substance use that are not problematic and that this is not true – that non-problem use is impossible. They argue also that such an implication normalises substance use (see **pro and anti-drugs**).

This objection is difficult to sustain for several reasons. Firstly the use of substances is present throughout human history and across human geography (see **abstinence**). In this sense, the use of substances is normal. Secondly, it implies that all substance use is harmful when the personal experience of the vast majority of people who use substances – alcohol and other drugs – is that their use is not harmful in any overly concerning way. They are in control of their use and make a risk assessment and seek to reduce harm – just as they do when they go cycling, do sports or choose what to eat. Thirdly it undermines people who have a substance use problem and trivialises the real issues they face by implying that all people who use substances (i.e. the majority of adults) have a problem.

In its work, SDF uses these terms and challenges, when appropriate, the notion that they are contentious.



Rat Park

The pioneering rat park experiment was first conducted by Bruce Alexander and colleagues at Simon Fraser University, British Columbia. This experiment was conducted to test the causes of well-evidenced 'addiction' in laboratory rats. Addiction in laboratory rats was established by showing that a rat held in a single cage with the ability to inject itself with drugs by triggering a specially designed mechanism, will do so and do so again and again. This evidence was used to assert that some substances were inherently addictive and that use lead to addiction.

In the rat park experiment, the researchers set out to see if the same kind of behaviour could be induced by the availability of the same substances in a different environment. Instead of a Skinner cage, rats were housed communally in a large area where they had access to drugs, food and water, nesting material, tin cans to hide and sleep in and wheels on which to exercise. They also had access to each other and so could socialise, form friendship groups and have sex. This environment was named 'rat park' by the researchers.

The results of the research are clear and have been repeated since by other researchers. Morphine and other drugs are not 'irresistible'; given other options rats opt to use drugs on very few occasions and no rat uses it repeatedly or compulsively. When it comes to passing time and living as a rat, there are better options than morphine or any other drug and given the choice rats will do something else. This experiment undermines the whole notion of drug use as a disease (see **disease model**) and even the notion of addiction as is commonly understood (see **addiction**) it reinforces the evidence laid out in the Vietnam veteran studies (see **Vietnam veterans studies**) and the importance of context of drug use (see **drug set and setting**).

In its work, SDF uses the evidence of the Rat Park study to interpret the experiences of people who experience problem substance use, and those who do not. SDF promotes awareness and understanding of the evidence base and challenges unhelpful notions around problem drug use including disease models and some notions of addiction especially when these have negative effects on people, the development of services and policy development.



Explore further:

Alexander, B (2010) 'Addiction: The View from Rat Park '
<https://www.brucekalexander.com/articles-speeches/rat-park/148-addiction-the-view-from-rat-park>

Recovery

This term originated in the USA and recovery remains an essentially Anglo-Saxon concept. Various definitions have been offered including the Betty Ford Institute definition: *Recovery from substance dependence is a voluntarily maintained lifestyle characterized by sobriety, personal health and citizenship. Sobriety refers to abstinence from alcohol and other nonprescribed drugs.*

The US Substance Abuse and Mental Health Services Commission (SAMHSA) defines recovery as, *a process of change through which individuals improve their health and wellness, live self-directed lives and strive to reach their full potential.*

Conservative Home Secretary Theresa May introduced recovery into a UK Government policy context in 2010. Although the document does not offer a definition of recovery, what was meant is indicated by the document's subtitle – *supporting people to live a drug free life.* In Scotland, the term was defined in the minority SNP Government's strategy document *The Road To Recovery* (2008) as *a process through which an individual is enabled to move on from their problem drug use, towards a drug-free life as an active and contributing member of society.* Some view these British definitions of recovery as less inclusive than those in the US.

In Scotland, the new strategy document *Right, Respect and Recovery* (2018) re-defines recovery as *a journey for people away from the harm and the problems which they experience, towards a healthier and more fulfilling life.* This may be viewed as a more inclusive approach than used under *The Road to Recovery* strategy (2008 to 2018).

As suggested by the range of these definitions, recovery remains a contested term. For people identifying as being in recovery, it may have very particular and profoundly personal meaning and connotations. In wider discourse, there is a debate around whether recovery means being 'drug free' and whether 'drug free' includes prescribed medication and substances such as nicotine and caffeine. (See **abstinence**; see **drug free**)

There are also issues with the frequently deployed metaphor of recovery being 'a journey'. For some, these issues impacted on perception, understanding and implementation of Government strategy under *The Road To Recovery* in the decade from 2008 (see **journey metaphors**).

In its work, SDF uses the term recovery in a way probably closest to the definition in *Right, Respect and Recovery* but perhaps better defined by The Chicago Recovery Alliance definition any positive change as a person describes it for themselves. SDF avoids using the term recovery where it may be misunderstood, cause confusion or cause unnecessary contention in discussion.



Recovery movement

This term has emerged in Scotland recently. In the strategy document *Rights, Respect and Recovery* the Scottish Government claims that 'over the last 10 years there has been a growing and thriving recovery movement.'

The term does not seem to apply to an established group or alliance of groups but to consist of people who self-identify individually or as part of a group as being part of a wider movement. The aims of such a movement remain unstated but seem to involve promoting the idea of recovery. (See **advocacy**; see **recovery**).

In its work SDF does not generally use this term as it is open to wide interpretation and may give an impression that there is a voluntary alliance of people with a declared and shared aim and purpose.



Recovery-oriented system of care (ROSC)

This is an American term that in a Scottish context has no fixed meaning. A 'system of care' usually refers to the services and wider support with which a person with a substance use problem might be engaged.

There is divergence in definitions in terms of which services might be included in a system of care. For example, would services available to people whether they have a substance use problem or not be included e.g. homelessness and housing services, social security or employability services?

There is also a question as to the extent to which a wide range of services often acting independently can be regarded as a system especially if a person has to navigate between and around those services independently. There are also different views about how much control anyone has in designing, managing and maintaining that 'system'.

There are, of course, also different views as to a definition of recovery means (see **recovery**; see **abstinence**) and therefore what recovery-oriented means; does that mean that the care system forces people to an outcome, encourages a particular outcome or simply that a specific outcome is simply possible within the system?

There is dispute over the extent to which services can and do support or promote recovery. There is a view that recovery necessarily happens outwith the treatment or care system. This view may preclude the existence or possibility of developing a ROSC.

In its work, SDF sometimes uses the term recovery-oriented system of care; this usually refers to a wide system of services and other supports including non-specialist services.



SDF acknowledges that such services, in effect, work as system that system produces outcomes that are both intended and unintended by the people who design or deliver services.

Systems may be 'recovery-oriented', in the sense that progress, as defined by the individual, can be supported within that system. In some cases, this happens and, in other cases, unfortunately, it does not. The quality of treatment and support services and the systems they form is a key focus of SDF's work.

Recreational drug use or recreational substance use

This term distinguishes between the experience of the vast majority of people who use substances and those people who develop a substance problem. (See **problem drug use**)

Objection has been raised on the grounds that all substance use is harmful. Even if it were conceded that all substance use is harmful (which would be contested) this does not mean that all substance use is problematic (see **problem substance use**). People take risks and experience harms every day – when they cycle, play sports and eat, for example. There are risks and some inevitable harms. There are processes – some of which a person may be unaware of and others of which a person may be conscious of – that mean that a personal and societal risk assessment, harm reduction has been undertaken and that these activities are undertaken in a way that involves 'acceptable' risk and harm. Substance use is, for the vast majority of people, the subject of similar risk assessment and harm reduction.

This term may also be contested in that its use may imply there is a distinct line between recreational and problem use. For some people this line is hard to distinguish and 'recreational', 'regular', 'heavy' and dependent use are not as distinct behaviours as is sometimes implied or inferred. This ambiguity can exist even for the person involved. People with a drug problem sometimes use phrases like 'I woke up with a habit' to describe the experience of suddenly realising their apparently controlled and 'recreational' use had become a dependency which may subsequently become problematic.

In its work, SDF uses this term but may more appropriately use terms like:



- non-problem use
- non-problematic use
- non-dependent use

Rehabilitation

Rehabilitation is used to describe the process of treatment and support of people with a substance problem and their own personal effort that aims to 'restore' them to health or a 'normal' life that they previously enjoyed.

There are issues with this term. Firstly, in addressing problem substance use people are not necessarily restored to good health – people may have physical and mental health issues some of which may be drivers for their substance use or consequences of their substance use (see **self medicating**).

Secondly, people may well not have had a 'normal' or a 'happy' life before they developed a substance use problem. They may not want to be restored to that life or that may be impossible.

The term rehabilitation seems to be rooted in a model of people's life trajectory – a more or less 'normal life' suddenly dominated and nearly overwhelmed by a period of problem substance use before a treatment and/or other intervention restores 'normality'. This is not the experience of many people who have a substance problem whose life, substance use and treatment and recovery experiences are far more complex.

In its work, SDF may use alternative terms as appropriate including:

- treatment and support
- (making) progress
- recovery



Relapse

People who stop or limit their use of substances for whatever reason, often subsequently use substances again. This is partly why medical definitions of problem drug use talk of a chronic or relapsing condition (see **addiction**; see **alcoholism**). Relapse can take on significance too in some recovery discourses where a relapse to substance use means that people have to 'start again' in terms of their recovery. One symbol of this 'starting again' is that some people will start counting their days of abstinence from zero again (see **clean**).

Relapse is sometimes regarded in ways which may be potentially damaging. It may be unhelpful for people to think of relapse as inevitable. It may also be unhelpful for people to regard relapse as catastrophic or a clear break from a previous episode of controlled use or abstinence.

Relapse is for many people associated with a period where support is needed and this may help the person in the short and long term. Unfortunately, it is a time when support is often withdrawn by family, peer and other supports and also by some services.

Relapse is closely associated with an elevated risk of overdose including fatal overdose (see **tolerance**).

In its work, SDF uses the term relapse to describe substance use after a period of more controlled use or abstinence. SDF works to ensure services and others understand the need to support people at a time of relapse and that people with a substance problem understand issues around tolerance. SDF also promotes understanding of relapse in understanding the role and effectiveness of treatment and support services improving Scotland's response to problem drug use.



Rock bottom

People who have a substance problem often experience unpleasant situations and circumstances. In retrospect, especially in the context of telling their personal story of substance use, problem substance use and recovery (see **personal narratives**) people may describe some sort of crisis or low point that, at the time or later, becomes significant in that it seems to have caused or motivated them to change and address their drug problem. Commonly this is referred to as rock bottom – a low point from which it became possible to push oneself back up again.

The concept is contested only in the sense that there may be an implication that for a person to begin to effectively address their substance use it is necessary to reach 'rock bottom' and have a particularly unpleasant experience. This is not the experience of all people who have addressed their problem substance use; others, for example, say that a realisation were growing older, boredom or a new personal relationship with a partner or a child was the significant change that motivated them.

It is worth noting that some people will describe a 'rock bottom' incident which for them, in retrospect, has significance; yet, when asked, they will concede that the incident was not the worst thing that ever happened to them or the worst situation they have been in. Also, when prompted, people will concede that, at the time, it did not motivate immediate change. It is possible that for some people a 'rock bottom' story is a device that helps them explain to themselves and to others the complex motivation and situation that caused them to address their substance use problem and why, on this occasion they were able to make progress while on other occasions they could not make or sustain progress.

In its work, SDF uses this term usually in describing a range of possible motivations and causes for people addressing their problem substance use, engaging with services or seeking other supports and points out that a 'rock bottom' is not necessarily required or inevitable.



Self-medicating or self-soothing or coping

Given the abundant evidence linking problem substance use to adverse life circumstances and events and mental health (see **adverse childhood experiences**; see **trauma**), it has been inferred that problem drug use, for some people, is a form of self-medication or coping mechanism. For some, the use of drugs makes what may seem overwhelmingly unpleasant situations bearable.

Interestingly the drugs people use may indicate the very form of unpleasant circumstance or symptom they are trying to medicate for. For example, people with attention deficit disorder (ADD) may self-medicate with stimulants and report that 'I need cocaine to feel normal'. What is actually happening is that the person is experiencing a paradoxical effect from the stimulant which they experience as calming and allowing them to focus and concentrate. Under different circumstances, people with ADD are often prescribed a stimulant (Ritalin, for example) and this paradoxical effect is well-documented in medical literature.

Likewise, people who suffer from anxiety or have problems sleeping may use benzodiazepines to alleviate these experiences – and these drugs are in fact prescribed for people with similar issues. In these cases, the drug use mimics and replaces the medication they may have been prescribed by a doctor. Early engagement with primary care or specialist services may have prevented this kind of drug use which can become very problematic and last for years.

People who use heroin describe the experience of it 'blotting out everything', insulating them from physical pain and from intrusive thoughts or anxiety. People describe early use of heroin as like being hugged or wrapped in a warm blanket. The comforting, protective nature of this experience is profound, especially for someone who otherwise lacks that comfort or has anxieties around building trusting relationships or is traumatised. (See **drug of choice**; see **adverse childhood experiences**; see **trauma**)

People who have a substance use problem involving alcohol sometimes report that the disinhibition that alcohol use involves allows them to engage in social situations or that it 'blots out' intrusive thoughts associated with trauma or that it helps them sleep.

The model of problem substance use as self-medicating is also demonstrated in cases where, when people reduce or cease their use of substances, for whatever reason, significant issues arise in terms of their mental health. This can happen also when OST medication is reduced. For a person using street drugs, without access to other support, there is a strong drive to increase the amount of drugs they use. This helps explain the relapsing nature of problem drug use (see **relapse**). For a person on OST these experiences can mean that their dose of medication is increased again. This explains why people are on medication long term and it can be difficult to come off OST (see '**parked on methadone**').

In its work, SDF often uses this explanation of some problem substance use because the evidence base is good and it reflects the personal experiences of many people who have a drug problem. It can also be a destigmatising explanation of problem substance use. For some people who have personal experience this insight is empowering and helpful in understanding and describing their own experiences.





Explore further:

Gabor Mate: Drugs, Set and Setting, International Drug Policy Reform Conference 2011 <https://www.youtube.com/watch?v=MNatUMUAmxg>

Stigma

In most cultures and societies there is control or the attempt to control substance use. The supply and use of substances is controlled by a variety of means including the law and taxation; religious strictures, social norms and mores, and by social taboo and stigmatisation.

The stigmatisation of people who use drugs and people who have a substance problem is complex.

Stigma takes different forms –

A person with a substance use problem may stigmatise themselves or internalise the stigmatising view that others have of them.

They may be stigmatised by the state, the society, the community, the family they come from. They may experience stigma when they engage with services, or in public settings.

Stigma may be 'contagious'. People who have a drug problem may find that their family or their community bear stigma related to their problem drug use. The services they use, including drug treatment services may be stigmatised.

Stigma may extend to people who have had a drug problem but now identify as being in recovery. It may even extend to people who do not have a drug problem but are perceived as likely to develop a drug problem.

Stigma may impact on some people every day; others, for example people in abstinent recovery, may only experience stigma if and when their status is made known. Broadly, none of this is contested. However, there is dispute regarding effective means of challenging and reducing stigma – or even agreeing that this is a desirable aim. The issue chiefly rests in terms of what is being destigmatised. Is the aim to destigmatise people who use substances, people who are involved in problem substance use; people who are in recovery? This matters because, in addressing stigma in one group, stigma may be promoted for another group. For example, a message that celebrates a recovery journey as a journey away from a stigmatised status and that therefore people who have stopped using drugs should not be stigmatised, actually promotes stigmatising views of people with a drug problem. This is why 'visible recovery' does not necessarily destigmatise people with a drug problem.

It has been suggested that 'stigma does not kill people'. However, this is contested as people's internalised stigma result in feelings of a lack of self-worth and inhibit their engagement with help and support from others, including services. Engagement in treatment is the most significant service provision in protecting people from overdose deaths.

In its work, SDF works to increase understanding and challenge stereotyping, prejudicial, judgemental and stigmatising views of people who use drugs, people with a drug problem and people in recovery. SDF work on anti-stigma activity that does not stigmatise others.



Substance abuse / substance misuse

These terms are used to cover all use of substances no matter what their legal status.

The terms abuse and misuse are contested and regarded by some people as judgemental, moralistic and inaccurate.

They may be regarded as inaccurate or stigmatising as people using substances are not necessarily using the product for a purpose for which it was not designed. They are not abusing or misusing the drugs. An exception may be claimed if people are using pharmaceuticals in ways that goes against advice from the supplier – i.e. a prescriber as opposed to a dealer. However, objection is given to this form of use – for example the abuse of prescribed medicines on the grounds that it is stigmatising and focusses on the behaviour rather than the cause. (See **alcohol abuse or alcohol misuse; drug abuse or drug misuse**)

It may be conceded by some that in the case of solvent use, the product is being used for a purpose for which it was neither designed or, in most cases supplied. However, the term is far more broadly applied than in this instance.

These terms may be regarded as derogatory or stigmatising to people with substance problem as it promotes the idea that that kind of use is wholly distinct from other people's use of the same substance which is not always the case.

In its work SDF avoids these terms and instead, as appropriate, may use:

- substance use
- problem substance use



Tolerance

People who use substances can develop a tolerance and so find that they need to use increased amounts to achieve the same effect. Many people who use substances have experience of this – including people who drink coffee, smoke tobacco or drink alcohol.

After regular repeated exposure to some substances, people report that they are not able to get the same effect that they had in the previously when they first used a substance or first used a substance after a long break from use.

Some people claim that the pursuit of this early effect has led them into problem use. This is sometimes called 'chasing it'.

There are physical and psychological aspects to tolerance (see **dependency**) and it is not fully understood or explained by physiological effects and processes.

A period of abstinence or reduction in use can reverse tolerance. This makes stopping using and restarting a period of high risk of overdose. Changes in the function of vital organs through illness or ageing can also reduce tolerance. Many overdoses including fatal overdoses are related to people having lowered tolerance. This seems to be more of a factor than variations in the strength of drugs supplied through illegal unregulated supply routes.

Some practices in services, for example, pushing people out of treatment who 'top up' with street drugs seem irrational if they are viewed from a perspective of changed tolerance. Difficulty ensuring people transition immediately from prison or hospital treatment services to community-based treatment can leave people exposed to risk of overdose and death due to changed tolerance.

The reason that people are on different doses of OST medication is related to tolerance which is not, as many people seem to believe, a proxy measure of a person's 'addictedness' or the extent of their drug problem or a measure of how close they are to abstinence or to recovery or 'how well they are doing'(see **optimal dosing** ; see **parked on methadone**).

In its work, SDF talks a lot about tolerance and points out the complexity and implications of this issue as appropriate.



Trauma

There is a complicated relationship between trauma and substance use.

For some people, the experience of trauma can be a root cause of problem substance use. This is true especially for people who experience traumatic events in childhood (see **adverse childhood experiences**).

For some people who have a substance problem the risk of experiencing trauma can be greatly elevated – this can be caused by a wide range of events that can be associated with problem substance use - experiencing and witnessing overdoses; bereavement through overdose and other causes; separation due to incarceration / hospitalisation; experiencing and witnessing violence; trauma through sexual and financial exploitation; losing access to children, for example. There are also traumatic effects of social marginalisation and stigmatisation (see **stigma**).

The link with trauma has influenced the development of the model of problem substance use as a form of self-medication or self-soothing (see **self-medicating**).

The high levels of trauma experienced by people with a drug problem dictates that services should be designed and delivered in ways that take account of this, be 'trauma-informed'. This means that services are designed and delivered in a way in which people who have experienced trauma can comfortably engage, that does not make their situation worse and acts as a sound basis and safe place from which people can address the health and other impacts of their trauma experiences including their use of substances.

The link to trauma suggests that finding ways to identify trauma and help people identify this as a driver of their substance use may be useful; it also suggest that helping people find other ways of addressing their trauma symptoms may help address their problem substance use; it may also challenge the stigmatisation of people with a substance use problem.

All of this is widely accepted and the term trauma is not contested widely. However, there is a danger that such an apparently coherent notion is universalised and that people who do not have a history of trauma or cannot recall traumatic events in their past or who do not wish to disclose events are alienated or treated as if or feel like their problem substance use cannot be 'justified' or explained.

The term trauma may be more useful than the term ACEs (see **adverse childhood experiences**) as it includes trauma in adulthood.

In its work SDF explains and raises awareness of the link between trauma and problem drug use for many people and promotes and supports good practice, trauma informed service design and provision.



Explore further:

Gabor Mate: Drugs, Set and Setting, International Drug Policy Reform Conference 2011 <https://www.youtube.com/watch?v=MNatUMUAmxg>

Treatment

The role of treatment and indeed whether treatment is necessary is contested in the context of problem substance use. Some people address their substance use problem without support from medical treatment services. In fact this may be the most usual means for people to resolve their problem substance use. Some people address their substance use outwith the context of 'addiction treatment' services but get support from other medical services. Many people acknowledge the support they received from 'addiction treatment' services as helpful but that wider supports are required to address their substance use problem.

A consensus view may be that medical and pharmaceutical-based supports can help people in addressing and resolving their substance use problem and in addressing some of the physical and mental health issues that are a cause and consequence of problem substance use but these are unlikely to be the only supports or services required.

Beyond medical treatment, there are a wider set of supports and services which may help people address their problem substance use and the causes and consequences of their use of problem substance use. These may be regarded as wider 'treatment'.

The aim of treatment is sometimes contested (see abstinence). Sometimes, this occurs because the definition of treatment varies. In treating chronic conditions there are pharmaceuticals that may give symptomatic relief allowing the patient to lead a more normal life, less affected by the symptoms of their condition. There are also medications that stop the condition becoming critical, for example for a diabetic patient, insulin prevents hypoglycemia that can lead to coma and death. People accept that these are treatments and that they do not 'cure' the person with the chronic condition. Likewise, opiate substitution therapy may offer patients symptomatic relief and may prevent health and other problem opiate use-related harms. It can also offer a person a basis to make other changes in their life (see **opiate substitution treatment**). To criticise this for not 'curing' a substance use problem is to misunderstand both the purpose of treatment and the nature of the problem (see '**parked on methadone**').

A question remains, what is the role of OST if a person on OST reduces or stops their street drug use but does not engage with other supports, for whatever reason. Is this treatment? It is, at it clearly has health benefits in reducing health risks and harms including fatal overdose and preventing withdrawal and other symptoms. It is also, and in this there is no contradiction, a harm reduction measure (see **harm reduction**).

In its work, SDF will distinguish between different aims of treatment and the potential benefits of medication and other elements of treatment including medical treatment and other support and wider social connections and the role of mainstream services including, for example, housing and employability services.



User involvement

There are various forms of activity that are described as user involvement. There are also a multitude of means by which user involvement is undertaken. There are significant issues in practicing effective user involvement.

The involvement of people who use services in evaluating and improving services is now common practice. There is general agreement that user involvement of this kind is fundamental to service improvement. In large parts of the public sector, including the NHS, such involvement is required. Regulatory bodies expect that user involvement is practiced within some services.

Other forms of involvement have also developed in the drugs field. This has meant that people are not only involved in service evaluation and improvement of the services they are using. People who have personal experience of problem substance use (see **lived experience**) can be involved in the design, commissioning, management and delivery of services and in the development of wider service provision and the development of policy.

This has led to various contested areas:

Who can be involved? Apart from people currently using services, the user involvement activity described above may, for some, also include;

- people who have who have previously used the service but no longer use it. This may include people who no longer require the service. There is an issue here surely of the currency of their knowledge of the service. If they are 'graduates' of the service their experiences may be untypical – have they benefitted or been failed by the service? Is this experience representative? Have they a perspective now which is not the perspective they had at the time they were engaged with the service and, perhaps, the general perspective of people at the time they use the service? Are they representative of the people using the service now?
- people who are not using a service but would be eligible and would perhaps benefit from using the service. This work may develop insight as to why services are inaccessible or unacceptable for some people.
- People excluded from current service provision.

There is also contestation of the methodologies of user involvement.

Should people be invited and supported into existing decision-making processes – meetings involving professionals and have 'a seat at the table'. How are people supported to do this and what are the real power dynamics in the status of people around that table? How representative of people using services are such 'users'? In professionalising their input, do they become less representative?

Should consultation processes include a wider range of people who are not interested in or able to attend and contribute to a long series of formal meetings with professionals using jargon

etc. but whose experiences and opinions can be captured in other ways and be represented by other peers? Peer research is designed to explore the potential of this approach.

Is there a role for personal narrative and what validity has the 'stand up and tell your story' approach? (See **personal narratives**)

In its work SDF is involved in delivering a range of user involvement activity for a range of purposes including the design, commissioning, management, delivery and evaluation of services and in the development of policy. SDF is keen that people actively using services and people who could benefit from improved services are involved in these processes. SDF is committed to a range of suitable effective methodologies which represent a broad representative range of personal experience and opinion and on necessary focus on the opinions and experiences of the most vulnerable and marginalised people within and excluded from systems.



SDF works to improve understanding and practice in this area and challenges poor practice and tokenistic participation.

Vietnam veterans studies

The studies of drug use and dependency among Vietnam veterans are some of the most important pieces of research undertaken in the drugs field. The results of these studies helped inform a new and deeper understanding of problem drug use and challenged medical, moral and ideological perspectives on drug use and problem drug use.

Lee Robins' research and report to the US Government on this subject is the most commonly cited work; her papers contribute to the extensive research on this subject. Her research on 450 US soldiers use of drugs before, during and after service in Vietnam. This work led to Norman Zinberg's own work on this subject (see **drug, set and setting**).

Robins used the results of urine testing of soldiers in Vietnam before their return and interviews on their return to the US and subsequently after 12 months which also involved a urine drug test.

The results were clear, soldiers regular use and dependency on opiates, usually heroin, in Vietnam was not continued on their return to the US and to civilian life. The very few exceptions to this were people who had used illicit drugs and specifically opiates in the US before joining the Army. This confounds notions of the 'addictiveness' of drugs (see **addictive**) as a driver for use and for 'addiction' and challenges the disease model of 'addiction' (see **disease model**; see **addiction**).

Interestingly, heroin use in Vietnam was closely related to having grown up in large US cities, and being less well educated by comparison with the rest of the sample and having a family history of drug use, crime and 'delinquency' (see **adverse childhood experiences**; see **poverty**).

In its work, SDF promotes awareness and understanding of the nature and cause of problem substance use and how people with a drug problem may be better supported. The clear research evidence on these matters is key to this work.



Explore further:

Hall, W., & Weier, M. (2016). Lee Robins' studies of heroin use among US Vietnam veterans: Robins' heroin studies of Vietnam veterans. *Addiction*.
<https://doi.org/10.1111/add.13584>

Robins, L. N. (1974) The Vietnam drug user returns: final report September 1973:
<http://www.webcitation.org/6icyp9VM5>

War on Drugs or The Drugs War

US Government repression of substance use and people who use substances has a long history – predating the period of alcohol prohibition in the early twentieth century. In the US drug prohibition has had a clear theme in focussing on and oppressing black communities in the USA and white people who associated with black people and their culture.

In June 1971, US President Richard Nixon, in a public address, declared an offensive against drugs and claimed that drug abuse had become “public enemy number one”. ‘In order to fight and defeat this enemy it is necessary to wage a new, all-out offensive’.

This was widely reported as The War on Drugs. This replaced his predecessor, Lyndon Johnson's War On Poverty which had been used to improve access to education and the economic problems of people living in poverty in the US – which included most of the African American population. In effect, the War on Drugs addressed a similar demographic and further criminalised and marginalised them

The global influence of US attitudes and policies has acted, through the United Nations, to make more and more oppressive policies in terms of drug production, supply and consumption through the use the subject of international conventions and treaties. The US has led diplomatic moves to ensure national ratification and compliance with these conventions threatening economic and political sanctions on those states that are reluctant or resistant.

All of this has been characterised as a war on drugs. However, it may be better understood as a

war on people who use drugs and on production and supply which are now almost entirely in the hands of national and international organised criminal gangs that distort and corrupt local and national economies and undermine government and other state systems. This occurs in almost every economy in the world. Several countries have become or almost become narco-states where all levels of the state are corrupted by drug-related organised crime and the state no longer functions. Each of these states finds itself in a state of almost continual civil war due to violence between drug cartels and between drug cartels, vigilantes, paramilitary forces and the armed forces. The US, of course, remains a major importer of drugs.

The War on Drugs also has a domestic front where national and local government oppress people who use substances and use the 'war on drugs' as a cover to marginalise, stigmatise and otherwise oppress individuals and groups. In the US Federal Bureau of Prisons statistics (June 2020) show that 46.0% of prisoners in the US are in prison for drug offences. The next most common cause is 'weapons, explosives, arson' with just 19.6%. In the UK, 15.0% of prisoners are in prison for drug-related offences.

It is argued that the war on drug is a war on people – and particular groups of people. It is argued that the war on drugs is a distraction from the real issues that cause problem drug use and other harms and which the state might otherwise address (see **poverty**). It is often argued that this 'war' has been a failure and causes harm. It is argued that this harm exceeds the harms that the laws and system were developed to prevent or that the harms exceed those that would be achieved through decriminalising possession or regulating drug production and supply. On another level it serves as a distraction from other issues that many Governments refuse to recognise or adequately address.

It is also argued that the war on drugs has failed because government oppression of people who use drugs has not been severe enough. This argument is used to increase and intensify aspects 'anti-drug' campaigns.

The main impact of the War on Drugs has been to frame drug-related issues and means by which they may be addressed as a question of whether they are pro- or anti-drug. This has corroded much of the discussion of drug-related issues and affected the policy and practical response to these issues. (see **pro and anti-drugs**).

In Scotland the war on drugs is usually mentioned in the context of the debate around decriminalising drug possession or legalising and regulating drug supply Framing the legitimate debate on these matters as part of the War on Drugs plays into simplistic notions that people or policy is 'soft' or 'hard' on drugs

The war on drugs stigmatises people who use drugs and people who have a drug problem, their families and communities (see **stigma**).

In its work, SDF does not generally use this term as it is divisive and has no shared common meaning. It is also unhelpful in contextualising debate around drug law or policy.





Explore further:

Nixon, R M '*Remarks about an Intensified Program for Drug Abuse Prevention and Control June 17 1971*' The Presidential Papers of Richard Milhous Nixon pp 738 – 749

<https://quod.lib.umich.edu/p/ppotpus/4731800.1971.001/804?page=root;rgn=full+text;size=100;view=image>

Nixon, R M '*Special Message to the Congress Drug Abuse Prevention and Control June 17 1971*' The Presidential Papers of Richard Milhous Nixon pp 739 – 749

<https://quod.lib.umich.edu/p/ppotpus/4731800.1971.001/805?rgn=full+text;view=image>

Gabriel Sayegh Drugs, “thugs,” and other things we’re taught to fear TEDx Binghamton University

<https://www.youtube.com/watch?v=RHrCfrXdVcc>

The first version of this document was published in September 2020. As language is evolving, this resource will be revised and updated periodically. If you have any comment on the content or suggestions for terms that should be included, please do not hesitate to get in touch.

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