

## WORKING WITH DRUG AND ALCOHOL USERS

Alcohol consumption in the UK has more than doubled since 1950, with the rate of increase particularly noticeable since the early 1990s. To some extent this may reflect greater disposable wealth brought about by the development of a more affluent society. Alcohol consumption is not bad in itself and its sensible enjoyment is the mark of a mature society at ease with itself.

However, increased consumption in Scotland has brought with it an increase in alcohol misuse. For some this may result in alcohol dependency, or manifest itself in 'binge drinking' and drunkenness. But for many people it is about regularly drinking over the sensible drinking guidelines, placing them at increased risk of harm. It is estimated that up to 50% of men and 30% of women are drinking over weekly sensible drinking guidelines and a majority of drinkers exceed daily guidelines on at least one occasion per week.<sup>20</sup> In addition, alcohol industry sales data shows that enough alcohol was sold in Scotland in 2007 to enable every man and woman over the age of 16 to exceed the sensible drinking limits for men (the recommended limit is 21 units per week) every week of the year.

Excessive consumption is not limited to particular sections of society but is common across different age and socio-economic groups. Interestingly more than half of alcohol sold is now consumed at home rather than in the pub, whereas home drinking represented less than a quarter of sales in 1980.

Worryingly significant numbers of children are also regularly drinking alcohol. In 2006 over one third of 15 year old boys and girls drank alcohol in the previous week. And a recent audit of Scottish Emergency Departments over a five week period found nearly 650 children were treated for alcohol related problems, including 15 under 12 years old and one as young as eight.

### *The importance of reducing consumption*

We know that consumption is closely linked to harm - the more we drink the greater the risk of harm. Over the last 50 years consumption has significantly increased in Scotland and so has alcohol-related harm. As a result, Scots are now more likely to be involved in an accident; to become a victim, or a perpetrator, of crime; or in the longer-term to develop cancer, liver disease or other health or social problems with knock-on consequences for families, communities and Scotland.

There are many examples of how a reduction in population consumption reduces harm. Alcohol consumption in France has fallen over the last 20-30 years, as have chronic liver disease and cirrhosis deaths. Whilst it is not entirely clear why, several factors are likely to have influenced the trend including a general fall in wine drinking, changes in occupational and lifestyle patterns (e.g. a move away from long lunches where wine was traditionally consumed), introduction of tougher drink driving laws and the introduction of the *Loi Évin*<sup>25</sup> to control alcohol advertising. Also of note is the widespread engagement in sport at both national and municipal levels providing positive alternative leisure and recreation choices. In Italy a fall in average population alcohol consumption led to a reduction in alcohol-related mortality.

What is clear from the international evidence is that if alcohol consumption falls, reductions in both acute (i.e. short term) harms (such as accidents and injuries) and chronic (i.e. long term) harm (such as liver cirrhosis) can follow within a relatively short time. Because the

harmful consequences of drinking too much are not confined to the heaviest drinkers, a reduction in overall consumption can be expected to have a positive effect on the whole population as well as reducing harm in high risk groups.

We need to achieve the societal change in Scotland which results in people using alcohol sensibly and in a way which helps to build healthier and more successful lifestyles for all.

Scottish Government, 2008, *Changing Scotland's relationship with alcohol: a discussion paper on our strategic approach*.

The full document can be downloaded from the Learning Exchange-  
[http://learnx.iriss.ac.uk/IntraLibrary?command=open-preview&learning\\_object\\_key=i03n89442t](http://learnx.iriss.ac.uk/IntraLibrary?command=open-preview&learning_object_key=i03n89442t)

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**The Misuse of Drugs Act (1971)** is the relevant piece of legislation pertaining to drugs (controlled substances). It categorises substances under Classes A,B and C.

### **Offences under the Act include**

- Possession of a controlled substance unlawfully
- Possession of a controlled substance with intent to supply it
- Supplying or offering to supply a controlled drug (even where no charge is made for the drug)
- Allowing premises you occupy or manage to be used unlawfully for the purpose of producing or supplying controlled drugs.

### **Classification under the Act.**

#### **Class A drugs**

**Include:** Ecstasy, LSD, heroin, cocaine, crack, magic mushrooms (whether prepared or fresh), methylamphetamine (crystal meth), other amphetamines if prepared for injection

**Penalties for possession:** Up to seven years in prison or an unlimited fine. Or both.

**Penalties for dealing:** Up to life in prison or an unlimited fine. Or both.

#### **Class B drugs**

**Include:** Amphetamines, Methylphenidate (Ritalin), Pholcodine, Cannabis.

**Penalties for possession:** Up to five years in prison or an unlimited fine. Or both.

**Penalties for dealing:** Up to 14 years in prison or an unlimited fine. Or both.

#### **Class C drugs**

**Include:** Tranquilisers, some painkillers, GHB (Gamma hydroxybutyrate), ketamine

**Penalties for possession:** Up to two years in prison or an unlimited fine. Or both.

**Penalties for dealing:** Up to 14 years in prison or an unlimited fine. Or both.

*Information sourced from: <http://drugs.homeoffice.gov.uk/drugs-laws/misuse-of-drugs-act/>*

## WORKING WITH DRUG AND ALCOHOL USERS

Substance use, substance misuse and dependency or addiction are not the same things. Substance misuse can be experimental, recreational or dependent, although it is possible to be in all stages at once with various substances. It is important to note that problems can manifest themselves at any of these stages. For example, volatile substance misuse can be fatal upon first usage. (Petersen, 2002, p27).

Why do some people use or misuse substances? There are a variety of reasons and influencing factors to explain why someone may start to use substances and continue to do so, including the age of the person, ethnicity, social class, peer and family influence, availability, cultural norms, and of course the fact that (mis)using substances can be enjoyable. That is to say, the positive factors more often outweigh the negative ones before the onset of problematic use. (ibid. pp24-27).

There are several theories which suggest why people experience problems with substance misuse:

**Gateway Theory** – the idea that misusing one substance acts as a gateway which can lead a person to misusing other more dangerous and damaging substances.

**Dependent Substance misuse** – can be psychological and/or physical and is demonstrated through behaviour and compulsion to misuse a substance for a prolonged period or continuously. (ibid. p28).

Petersen suggests that there are biological, psychological and sociological models which can be applied to dependent substance misuse theory.

**BIOLOGICAL** – involves the study of the biochemical links between a person and a substance, and it is also concerned with the investigation of hereditary and genetic links.

**PSYCHOLOGICAL** – these theories relate activities understood to take place in the “mind” of the substance user, as opposed to the physical brain. They include classic conditioning, operant conditioning, expectancy theory, social learning theory, and the stages of change model amongst others.

**SOCIOLOGICAL** – Environmental and sociological explanations are concerned with factors relating to the environment someone lives in and other considerations such as social deprivation. (ibid. p29-35).

A good practitioner ought to have a understanding of all these approaches to explain dependency, and whilst it is understood that workers may be more closely aligned to one approach depending upon professional training, education and the sector they work in, there are useful contributions to be made from each of the proposed explanations.

Petersen, T. & McBride, A. (eds), 2002, *Working with Substance Users: A Guide to Theory and Practice*, Oxon: Routledge.