

Occasional and controlled heroin use

Not a problem?

Hamish Warburton, Paul J. Turnbull and Mike Hough

This report explores the patterns of heroin use among a population of non-dependent and controlled dependent heroin users who saw their use as relatively problem-free.

Little is currently known about groups of occasional and controlled heroin users. This study, conducted by the Institute for Criminal Policy Research, aims to improve our understanding about patterns of heroin use, the nature of dependence and ways of controlling it.

The study describes how this largely hidden population maintained stable and controlled patterns of heroin use. It examines reasons for starting to use heroin, previous and current patterns of use, mechanisms and factors that helped to control use, and why this group saw their use as fairly problem-free. The report draws on a series of in-depth qualitative interviews with heroin users and on an internet survey.

Heroin is a dangerous drug. It can have a devastating impact on individual lives, on users' families and on the wider community. However, as the report shows, *some* people, in *some* circumstances, can effectively manage and regulate their use. This raises important issues for treatment. Can dependent and chaotic heroin users learn from the experience of this group? Should controlled heroin use be regarded as an acceptable short- or middle-term goal for clients of drug treatment services? Should popular beliefs about the inherent uncontrollability of heroin dependence be left unchallenged?

The report deconstructs some of the myths surrounding heroin use and heroin dependence. It is relevant to policy-makers, those working in the drug treatment field, academics and drug researchers.

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Summary

Little is currently known about hidden populations of occasional and controlled heroin users. This report presents the results of research into this group. The study comprised an internet survey of 123 users and in-depth interviews with 51 users. By examining this subset of heroin users, the study aims to improve our understanding about patterns of heroin use, the nature of dependence and ways of controlling it. The research found that:

- The two samples differed from those recruited from treatment or criminal justice populations. Almost all respondents were in work or studying, and they were much more affluent than treatment samples. They also had better accommodation, mainly owning or renting their own homes.
- Their heroin-using careers varied. Some reported patterns of mid- or long-term non-dependent use. Others had moved from dependent and problematic use to non-dependent use. A third group maintained patterns of controlled dependence over the mid- to long-term.
- Respondents took great care over where they used heroin and whom they used with. Most avoided using with people who were deeply immersed in the heroin subculture or involved in crime.
- Avoiding those involved in the 'heroin scene' and being discreet about their use enabled them to maintain identities with no associations with uncontrolled use, 'junkies' and 'addicts'.
- Controlling heroin use is a complex process achieved by different people in different ways. Those who were interviewed in depth reported a range of different strategies for avoiding dependence, or for retaining control over their dependence.
- Non-dependent users tended to follow rules that enabled them to restrict the *frequency* with which they used.
- Dependent users aimed to contain the *amount* of heroin that they used on a regular basis, to ensure that their use did not intrude into their everyday work and social routines.

Early heroin use

Most people in our samples began using illegal drugs in their teenage years. Patterns of initiation bear much resemblance to those described in surveys of the general population. First use of heroin, on average, occurred at age 20 for those who completed the online survey and a little later for in-depth interviewees. Few people started their drug careers using heroin. Most had experience of at least one other drug, mainly cannabis, before trying heroin. Many respondents reported having moderate or extensive experience of other drugs before trying heroin.

Reasons for trying heroin were complex. Nearly all respondents reported trying heroin because they chose to, not because they felt pressured or coerced into it. Most reported trying the drug out of curiosity, although the first experience for a few was prompted by instrumental as opposed to hedonistic purposes

– for example, to ease the ‘comedown’ from other drugs. A small number also described how trying heroin corresponded with, or was related to, a critical moment in their lives.

Few non-dependent and controlled dependent users consciously sought out heroin. Most encountered it by chance through friends. The process of ‘peer preference’ – the gravitation towards like-minded people – provides a useful framework for understanding why people tried heroin.

Patterns of heroin use

Heroin careers can be fluid, varied and hard to define. Patterns of heroin use described to us are at odds with popular beliefs about heroin use.

Interviewees ($n = 51$) reported patterns of:

- stable mid- to long-term non-dependent use without ever incurring a period of dependence (13 respondents)
- mid- to long-term non-dependent use after experiencing a period of dependent/problematic use (22 respondents)
- stable mid- to long-term controlled dependent use (nine respondents)
- transition (i.e. recent dependent or problematical use) and new using (seven respondents).

These findings show that some people can use heroin for prolonged periods of time without becoming dependent. They show that some people can use heroin dependently, but in a stable and controlled way that causes few of the problems typically associated with the drug. Some interviewees had also switched from

problematic patterns of use to stable, controlled or non-dependent patterns of heroin use.

Contrary to popular assumptions about heroin use, the findings suggest that heroin use does not lead inexorably to dependence and that chaotic use is not an inevitable outcome of dependence. Importantly, it also shows that some people can bring their heroin use back under control after periods of uncontrolled or highly problematic use. Interviewees were careful about where they used heroin and whom they used with. This allowed them to use heroin in a safe, comfortable and relaxing environment.

Regulating and controlling heroin use

Controlling heroin was a complex process achieved by multiple means. Much depended on the individual, how they used heroin and their personal situation. The following factors – which are by no means mutually exclusive – helped respondents regulate their heroin use:

- the application of ‘using rules’ – including rules about *frequency* and *amount* of heroin used, access to the drug, where an individual used heroin and with whom
- their expectations of the physical and mental effects of heroin
- life structures and commitments – for example, being employed, having stable accommodation arrangements, maintaining good family and social relationships, and having non-heroin-using interests and friends

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- attitudes and personality traits – such as a generalised ability to exercise control over their lives
- their own experience of heroin use, or indirect experience – such as witnessing the damage done by heroin to friends' lives
- the perception of the stigma attached to uncontrolled or dependent use, and their desire to avoid stigmatisation.

The presence and importance of the factors described above differed depending on the individual and on whether they were non-dependent or controlled dependent users. For example, most non-dependent users placed greater emphasis on avoiding direct access to heroin sellers and on the application of 'using rules' which helped to set boundaries within which responsible use could occur. On the other hand, a number of controlled dependent users were more reliant on having stable lives. Stability and life structure were important factors that enabled this group to develop the resources and skills to control their heroin use.

The nature of the causal links between stability of lifestyle and controlled heroin use is, of course, complex, and will vary from person to person. On the one hand, structure, commitments and stability of lifestyle may both protect people from the strains and stresses that push people towards uncontrolled use of heroin – or of alcohol or other drugs – and provide habits of self-discipline and self-command. Equally, those with jobs, families and friends have much more to lose from uncontrolled drug use than those who are more socially marginal, and develop identities that are inconsistent with

uncontrolled drug use. But on the other hand, there are individual differences between people that mean that some people simply display more self-command than others, and the former are likely to be able to impose more structure and control than the latter both on drug use and on other aspects of their lives.

For controlled dependent users, the degree to which heroin had become an integrated part of their life affected their perceptions of their use. Most did not see themselves as 'addicts' in the traditional sense; they did not view their use as a debilitating affliction or consider themselves to be a 'slave' to the drug. Rather they made rational and autonomous decisions about how best to manage and regulate their daily heroin use.

Perceptions of heroin use

The consensus amongst our sample was that heroin use only became a problem once it began to intrude into their everyday lives – for example, in affecting their employment, health or relationships. Interviewees perceived heroin to be viewed negatively by non-users and society at large. Many felt that thinking about heroin was shaped by discussions and representations in the media, which often portrayed heroin users as evil, untrustworthy, uncontrolled and morally corrupt. Not fitting society's stereotype of a heroin user, most interviewees were keen to avoid being labelled or thought of in this way. This prompted most of them to hide their use from those around them.

Protecting self-image and rejecting the 'junkie' identity

An important component of control that runs throughout this report is users' sense of identity or self-image. By controlling their using environment so that they avoided uncontrolled users or those further immersed in the heroin subculture, respondents were able to distance themselves from 'junkie' or 'addict' behaviours. Many respondents – particularly controlled dependent respondents – articulated the benefits of having commitments and obligations, feeling productive and having a stake in society. This served to distance them from the stereotypical image of a heroin user described above – it helped them to reject the 'junkie' identity. Hiding their heroin use from those around them enabled this group to function in society without being thought of as heroin users; they were able to go about their daily lives without being labelled and stigmatised.

These decisions meant that most interviewees did not think about themselves as 'addicts' and therefore did not abdicate responsibility for their drug use. Protecting their self-image, avoiding being labelled and rejecting the junkie image undoubtedly contributed to respondents' motivation to control their heroin use.

Implications for policy

It is incontestable that heroin can have a devastating impact on individuals, families and the wider community. However, heroin affects people in different ways and some people, in certain circumstances, can effectively manage

their heroin use so that it causes them few problems. Learning about controlled heroin use could serve to help reduce problem drug use. It is important that this fact is recognised and that constructive lessons are drawn from it.

Some people will argue that it is irresponsible to draw attention to groups of heroin users who manage to control their heroin use. The argument is that downplaying the risks will inevitably result in more widespread use and greater suffering. We would argue that in drugs prevention honesty is always the best policy. Those who are the target of drugs education are highly sensitive to exaggerated messages, and will discount these. We also think that sustaining a popular belief in the *inherent* uncontrollability of heroin dependence could itself have perverse consequences. Drug dependence is to some extent *socially constructed* – in the sense that public beliefs about drugs such as heroin determine how people actually experience them. It is possible – but not provable – that the way that public stereotypes of heroin use are deployed may help create the highly destructive role of 'junkie' that many heroin users occupy. In a world in which heroin is increasingly available, policy should do all that it can to undermine this stereotype.

We think it a sensible and realistic policy aim to encourage users to take greater responsibility for regulating their drug use. This might involve improving popular understanding of the drug and changing the way people think about heroin use. The concept of controlled heroin use ought to be developed into an accepted treatment goal for clients of drug treatment services who are attempting to stabilise and manage their heroin use – in much the same

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way that controlled drinking is an accepted treatment goal for some problem drinkers. Heroin users need to be given greater awareness of the 'using rules' that our respondents followed to help them control their use.

It is now broadly accepted in Britain that harm reduction is the 'least worst' option in handling drug dependence – for example, it is

better for injecting drug users to have access to clean syringes than face the risks of blood-borne viruses. By the same token, policy should do all it can to discourage heroin use, but these efforts should stop short of denying information to users about strategies for reducing the risks of dependence.

1 Introduction

Since heroin was first synthesised from opium at the end of the nineteenth century, its non-medical use has been steadily increasing. The 1916 Defence of the Realm Act made possession of opium-based drugs – opium, morphine and heroin – a criminal offence. The Dangerous Drug Acts of 1920 and 1923 provided the framework for regulating importation, manufacture, distribution and sale of opiates. However, it was not until the 1980s that political and public anxieties about heroin became salient in the United Kingdom. This was in part due to the advent of HIV/AIDS and the risks of viral infection posed by needle sharing. But the increasingly widespread use amongst the urban poor and the growing association between heroin use and crime have also fuelled concerns. Government policy currently focuses heavily on the misery caused by users of heroin (and other Class A drugs) to themselves, their families and communities (HM Government, 2002).

Political, media and public debate is grounded on various taken-for-granted assumptions. The central ones are that using heroin leads inexorably to addiction, and that addiction leads to problems such as involvement in crime and deterioration in physical and mental well-being.¹ It is incontestable that heroin has the capacity to be individually and socially destructive. However, some people – as the literature below demonstrates – are able to use the drug over prolonged periods in a relatively problem-free way. Most of these users are not in touch with treatment services and most hide their use from those around them. This study focuses on such a group of occasional and controlled dependent heroin users.

It is important to examine this subset of users. Understanding the ways they use heroin

helps us to understand the nature of dependence more fully, and it also points to tactics for helping dependent heroin users control their drug usage.

Dependence and controlled use

In the alcohol field the concept of controlled drinking is now a widely accepted one (Cox *et al.*, 2004). The situation is rather different in the drugs field. For many years the possibility of non-dependent and controlled heroin use has been largely ignored. Similarly, it is rarely recognised that there can be forms of dependent heroin use that bring few of the problems usually associated with the drug. The highly politicised nature of drug policy means that in their public statements politicians and their advisers will tend to stress that *all* forms of illicit drug use are problematic.² Given the media treatment of heroin and public concerns about drug use, it is to be expected that politicians adopt a firm and uncompromising opposition to the drug. In this context, it is hardly surprising that the possibility of controlled heroin use has not been officially recognised.

The dominant model of dependence, often labelled the ‘disease’ or ‘medical’ model, emphasises dependence and the problems associated with it as an inevitable and physiological consequence of heroin use. Interventions delivered within the health service have often been conceptualised as a technological treatment or cure for a medical illness. This is also a central tenet of 12-step programmes such as Narcotics Anonymous. Amongst health professionals, some academics, politicians and the public there is a widely held belief that the pharmacological properties of

heroin generally draw users inexorably into dependency, which in turn leads to varying degrees of personal degeneration (George, 1993).

However, an overlaying set of moral assumptions can also be identified, according to which heroin use reflects a moral deficit. Media discussion of heroin use in particular is skilful at fusing the assumptions of the disease model with those of moral decadence, with purple metaphors of entrapment and enslavement (see Hough, 1996). The dominant views about heroin use, therefore, presuppose it to be *inherently* problematic, because of either its pharmaceutical properties or its capacity to corrode moral purpose. The belief is that users quickly lose the ability to control and make conscious, autonomous or rational decisions about their use.

However, there is some evidence that contradicts such beliefs. The most often cited counter-example is a study of US army veterans who found that few of those who had been using heroin in Vietnam continued to do so dependently on their return (Robins *et al.*, 1974; Robins *et al.*, 1977). Building on this work, Zinberg (1984) conducted the best-known study in this field. Amongst a larger group of drug users he identified 61 individuals who exhibited signs of 'controlled' patterns of heroin use. This group had been using no more than once a week for at least two years, and their use appeared not to interfere with family life, friendships, health or employment. In the UK, Blackwell (1983) identified and conducted in-depth interviews with 51 non-dependent heroin users. Blackwell described those in the sample as either 'drifters' (those who used heroin occasionally without employing any methods of

control) or 'controllers' (those who controlled their use through individually developed 'using rules'), and also described how a number overcame a previous period of dependence to use in a non-dependent way.

More recently, Shewan and Dalgarno (2005) mounted a longitudinal study of 126 long-term heroin users in Glasgow who had never undergone treatment. They found that some users carefully planned and controlled their use, incurring fewer negative social and health outcomes – in sharp contrast to other researched groups of heroin users.³ Another recent study of the links between street crime and drug use demonstrated that criminally active heroin users could, in certain situations, control their heroin use and therefore their participation in crime (Allen, 2005). Allen described groups of users who only took heroin when they were paid or received their giro or as a reward, and a group who were dependent but when they had no money would endure heroin withdrawal or buy methadone rather than commit crime to fund their use.

The research literature provides clear evidence that some people are able to use heroin in a non-dependent or controlled manner (Robins *et al.*, 1977, 1979; Zinberg and Harding, 1982; Blackwell, 1983; Zinberg, 1984; Shewan *et al.*, 1998; Shewan and Dalgarno, 2005). Likewise several studies have demonstrated that cocaine too can be used in this way (Cohen and Sas, 1993, 1995; Ditton and Hammersley, 1994; Decorte, 2000). Much of this limited body of literature also argues that drug research has tended to underplay the importance of individual attitudes towards the drug, the social context in which it is used and the impact this has on an individual's experience of drugs and

their effects (Zinberg and Harding, 1982; Zinberg, 1984).

How do people control their heroin use?

Several sociological researchers have described and attempted to explain the phenomenon of controlled drug use. Though it did not specifically address issues of dependence, Becker's (1963) classic work on becoming a marijuana user has some important insights about learning to use drugs. Becker notes that learning to experience the effects of a drug is not the only factor that generates stable use. He outlines how social rules of the dominant majority are broken down and replaced by an alternative set of rules developed within smaller using groups. Becker suggests it is these alternative group rules that determine the parameters within which drug use is deemed acceptable, and thus have an impact on an individual's ability to control their drug use (Becker, 1963, pp. 59–78). Becker also discussed the importance of socially organised knowledge about drugs. He referred to this as 'social pharmacology'. The process relates to ways in which the organisation of knowledge about drug use translates into certain expectations, and it is these expectations that help to shape an individual's experience of the drug (Becker, 1967, 1977).

Drawing on the work of Howard Becker, Zinberg developed a three-factor model of control which focused on the complex interplay between the properties of the substance ('drug'), attitudes to the drug ('set') and the social context in which it is used ('setting'). Zinberg argued that social context and individual attitudes and perceptions about drug use are largely responsible for generating control. In

particular, he regarded the development of informal control mechanisms (social sanctions, rituals and rules) within the 'setting' as pivotal. Zinberg's theory has been criticised for not taking into account the multidimensional nature of self-regulation or the intra-group variation in the effective deployment of these mechanisms of control (Grund, 1993). Grund developed Zinberg's theory to include other factors that may impact on control, particularly 'drug availability' and 'life structures'.⁴

Others have gone further and argued that dependence (a perceived inability to control the compulsion to use heroin) and problem drug use are socially constructed concepts, which are given meaning by an individual's social context (Moore, 1992). Moore suggests that having a stake in conventional society and involvement in non-drug activity creates a social context whereby individuals have a sense of identity, structure and purpose, which enables them to exert a degree of control over their drug use. This idea has been developed further and it has been suggested that there is a 'sociopharmacology' of drug use (Friedman, 2002). Advocates of this perspective argue that those who are more susceptible to the social pressures associated with inequality of opportunity or have experienced particular social problems are more likely to develop problem drug use. However, these problems are not necessarily the fault of the individual or the drugs themselves, but can be located in a broader socio-economic context (Freidman, 2002).

Importance for policy

Few British studies during the past 25 years have examined patterns of non-dependent or controlled heroin use. Much has changed

during this time. Availability of heroin has increased dramatically, whilst cost has continued to decline. Use of heroin has diffused across age groups and geographical areas; it is no longer a form of drug use monopolised by young men and women living in deprived inner-city areas, as it was during the 1980s (Parker *et al.*, 1998b). Parker and colleagues described how, throughout the 1990s, a series of ‘new heroin outbreaks’ occurred in small towns and cities with no previous history of heroin availability. Increasingly there have been reports of heroin use amongst groups of drug users not normally associated with the drug, for example those using heroin to ‘come down’ after taking dance drugs (Parker *et al.*, 1998a; Lloyd *et al.*, 2002). Over the past 25 years the nature and extent of heroin use in Britain have changed.

For those who acknowledge the existence of controlled heroin users, the common assumption is that they comprise a small minority of the overall population of heroin users. However, some research has contradicted this belief, suggesting that non-dependent or controlled users outnumber those whose use is uncontrolled and problematic (Hunt *et al.*, 1976; Flaherty *et al.*, 1984; Hartnoll *et al.*, 1985). Survey evidence in Australia has shown non-dependent use to outweigh regular dependent use (Makkai and McAllister, 1998). We have no way of knowing whether this is true of using patterns in Britain.⁵ Whether the proportion of heroin users who are non-dependent or dependent but stable and controlled in their use accounts for 10, 50 or 75 per cent of the overall population of heroin users has important implications for the focus afforded to this group by policy.

This study is premised on the view that policy must be based on a rounded

understanding of the problem it needs to address. In our view, this is not currently the case for heroin policy. There is a reticence to acknowledge that controlled use of heroin is a reality. We know a great deal about the estimated 340,000 problematic users⁶ in England and Wales (Godfrey *et al.*, 2002), yet we know very little about the more hidden population of controlled users. Learning more about this group may yield many benefits. We can achieve a better understanding of those who cannot control their drug use by comparing and contrasting them with those who do so successfully. And a better understanding of controlled use could provide treatment services with new techniques for helping chaotic users. There is also scope for developing harm reduction strategies to help new users maintain control of their drug use – if they cannot be dissuaded from trying and continuing to use heroin.

Defining terms

A formal definition of ‘problematic use’ has been provided by the Advisory Council on the Misuse of Drugs (ACMD). The ACMD definition is:

Anyone who experiences social, psychological, physical or legal problems related to intoxication and/or regular excessive consumption and/or dependence as a consequence of his/her use of drugs or other chemical substances.

(ACMD, 1982, p. 34)

As the risks posed by HIV / AIDS became more apparent, the ACMD (1988) broadened this definition to include anyone whose drug use involves, or could lead to, the sharing of

injection equipment. Another definition is provided by the European Monitoring Centre for Drugs and Drug Addictions (EMCDDA). The EMCDDA proposes that problem drug use involves:

... injecting drug use or long duration/regular use of opiates, cocaine and/or amphetamines.
(EMCDDA, 2004)

Both definitions are limited in their scope: the ACMD definition because of its 'all encompassing' nature and the EMCDDA definition because it implies that regular use of opiates will inexorably cause users problems.

To define 'controlled use', Zinberg and colleagues applied two measures: quantity of use (size and frequency of dosage) and quality of use (how the drug is used or the conditions in which it is used). Zinberg (1984, p. 43) classified those users who exhibited signs of dependence – 'very frequent use' or 'repetitive use' – as compulsive and not controlled users. Importantly though, it was acknowledged that compulsive users did, to different degrees, control their drug taking.

Dependence in itself, therefore, may not be sufficient to generate problematic or uncontrolled use. Another important dimension to consider is that relating to stability of drug use and lifestyle. One possibility is that occasional and controlled users simply manage to defer, longer than most, the onset of problems associated with dependence. On the other hand, it might be that they can maintain a stable habit, together with a stable lifestyle, over a period of years. The latter group obviously has a stronger claim to be problem-free than the former.

There is no clear definition of 'controlled' heroin use in the research literature (see

Harding, 1988). Terms such as 'recreational use', 'intermittent use', 'occasional use', 'sporadic use' and 'casual use' are employed interchangeably. Recently Shewan and Dalgarno (2005) suggested using the term 'unobtrusive heroin use'. This term has merit as it allows for different patterns of use on the understanding that use is unobtrusive both for the individual user and for society.

In this report, we shall use the term 'non-dependent use' to refer to use whose cessation is not accompanied by physical symptoms of withdrawal. In Chapter 3, non-dependent use is broken down into two subgroups: 'occasional non-dependent' users (those who use heroin less than once a month) and 'frequent non-dependent' users (those who use at least once a month, but are not dependent on heroin). Throughout this report, the term 'controlled dependent' refers to dependent users⁷ (i.e. users who would experience withdrawal symptoms if they stopped using) who perceive their use to be controlled and largely problem-free. This group would be defined by both the ACMD and the EMCDDA as problem users.

Aims and methods

This research focuses on a largely hidden population of non-dependent and controlled dependent heroin users who perceive their use to be on the whole problem-free. The research describes the factors that enable people to manage their use of heroin and avoid problems. In particular, it aims to describe:

- the circumstances surrounding initiation into drug use (and heroin use in particular)

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- drug-using histories and current patterns of heroin use
- how heroin use is controlled and managed
- heroin users' perception of their use as largely problem-free and reasons for controlling use
- heroin users' reactions to escalating use and the onset of problems.

A key aim of this study is to understand more about how and why heroin use is not experienced by some people as a problem.⁸ Thus it made little sense to employ rigid recruitment and selection criteria. Participation in the study was based on:

- self-identifying use as relatively problem-free
- having used heroin at least once in the last six months
- not having any current heroin-related legal problems
- not having any significant health problems related to current heroin use.

Non-dependent and controlled dependent heroin users are clandestine about their drug use, and thus a hard-to-reach group. Our research strategy was designed to overcome this problem. One of the methods we used was an anonymous and confidential online survey of heroin users (available at www.usingheroin.com). The survey was advertised in a variety of mainstream magazines, by sending flyers to universities and treatment services, placing requests for participants on drug- and non-drug-related

internet discussion forums, disseminating information about the study via organisational e-newsletters, and through other organisations hosting links to the survey on their websites. The criterion for participation was having used heroin at least once during the last six months. Data from the online survey were collected between December 2003 and March 2005. During this period 246 respondents completed the survey.

Of these, 123 met our criteria for non-dependent and controlled dependent heroin use; they had used the drug at least once in the last six months and self-identified their use as relatively problem-free. Ninety-four respondents described their use as problematic. The remaining 29 respondents were removed from the sample because they failed to meet the entry criteria or because their response was considered either inconsistent or fabricated.

Using the World Wide Web to conduct a survey of drug use made it difficult to restrict participation to UK residents alone. Our sample of 123 non-dependent and controlled dependent heroin users is a multinational one: 49 per cent ($n = 61$) were from the United Kingdom, 30 per cent were from the United States and the remaining 20 per cent were from a variety of other countries – predominantly Australia and Western Europe.

This posed certain problems, as different countries have different sets of social, cultural and economic factors that influence the way people use drugs and how they think about their drug use. The biggest problem is whether the findings drawn from respondents living in other countries have any relevance to the UK. We felt that they do, bearing in mind two points. First, nearly all non-UK respondents

came from developed Western nations – America, Canada, Australia or Western Europe – with similar prohibition-based drug control systems. This meant that their using patterns were governed by broadly similar constraints. Second, we only present findings that can be substantiated by the in-depth interviews, which were conducted solely with participants from the United Kingdom.

We undertook 51 in-depth qualitative interviews. Interviewees were recruited from the online survey and by asking research participants to pass on our contact details to other users. By doing this, we were able to tap into research participants' networks of friends and contacts. Overall 17 respondents were recruited directly from the survey, and a further 37 were recruited using the 'snowball' sampling techniques described above (see Appendix 1 for additional details). Face-to-face interviews provided an opportunity to investigate views, beliefs and practices in greater detail and to describe participants' experiences and strategies in their own words.

Both the online sample and the interview sample shared the basic demographics of users documented in other studies, including research into dependent use. Both samples comprised, largely, white men in their twenties and thirties. However, there were some systematic – and unsurprising – differences between our samples and those recruited from treatment or criminal justice populations. Almost all of our two samples were in work or studying. They were much more affluent than treatment samples. They had better accommodation, mainly owning or renting their own homes, and were generally in established relationships. There were some respondents in their forties and

fifties. We cannot say, of course, to what extent this reflects our methods of recruitment, as opposed to characteristics of controlled users. Any internet-based recruitment necessarily includes only those people with access to computers, and favours those who can afford broadband access.

We have largely taken our respondents' accounts at face value. We recognise, of course, that accounts of drug use are sometimes self-serving, self-deluding or even self-consciously campaigning. The only checks we could exercise on the internet sample were those that examined internal consistency. We think – but cannot prove – that our sample had little vested interest in deception. Data for a small minority were discarded on the grounds of obvious inconsistency. We feel more confident about our interview group. Interviewing someone for an hour or more provides ample opportunity to form judgements about honesty and consistency.

Full details of the methodology can be found in Appendix 2, including demographic breakdowns of the two samples and comparisons of these samples with those typically representing problem users.

A cautionary note

Debate about heroin use raises strong emotions. We appreciate that some readers will regard this research, and the conclusions that it draws, as irresponsible promotion of drug use. This is not our intention. We fully recognise – and emphasise – that heroin can have a devastating impact on people's lives, and on their families and the wider community. This study describes how a small minority of people managed to

effectively control their heroin use. We do not believe that controlled and problem-free use is a universal possibility. Our argument is simply that heroin affects people in different ways, and that some people, in some circumstances, can effectively manage and control their use. In much the same way, some people develop intense dependency on nicotine, smoking 40 cigarettes a day, whilst others are able to restrict their use to the occasional 'social' cigarette. We think it important to recognise the extent of variation in the use of drugs of dependence – and to learn from it – so that we are better equipped to face the real problems that these drugs now pose.

The structure of the report

Chapter 2 describes early patterns of heroin use and how users first came to try the drug. Chapter 3 examines current patterns of heroin use (and other drugs), where the sample used heroin, who with, and what they enjoyed about it. Chapter 4 examines the factors that enabled our in-depth interviewees to manage and control their heroin use. Chapter 5 considers users' perceptions of their heroin use. Chapter 6 summarises the key findings, discusses the relevant issues and highlights implications for policy.

2 Early heroin use

This chapter describes how our sample came to use heroin and the circumstances surrounding first use.

Early patterns of drug use

Early onset of drug use has been highlighted as a risk factor associated with future problem drug use (Lloyd, 1998). Studies of drug treatment clients – problem users participating in probation schemes or in receipt of a Drug Treatment and Testing Order – have reported first use of an illegal drug occurring at the age of 14 or 15 years (Edmunds *et al.*, 1998; Hearnden *et al.*, 2000; Turnbull *et al.*, 2000; McSweeney, 2005). Previous research has also highlighted early patterns of illegal drug use to be common amongst ‘vulnerable’ groups of young people. For example, studies of young offenders (Hammersley *et al.*, 2003), those in local authority care (Ward *et al.*, 2003) and the homeless (Wincup *et al.*, 2003) have reported first drug use occurring at the age of 13 or 14 years, and first use of heroin occurring between the ages of 15 and 18 years.

Use amongst our sample of non-dependent and controlled dependent users began a little later than that reported in the studies of vulnerable groups, but around the same time as

that of research samples of problem users in treatment. As with other users, illicit drug use largely started during teenage years. The average age of first use of any illegal drug for those who completed the online survey was 15 years (range 10–23 years) with 70 per cent first trying an illegal drug between the ages of 13 and 16 years. First use of heroin occurred, on average, five years later at 20 years (range 12–60 years). The qualitative interviews show a similar pattern, although the time between trying their first illegal drug and trying heroin tended to be a little longer. Online interviewees reported using a variety of different types of drugs prior to trying heroin, as can be seen in Table 1.

Few people from our multinational online sample started their drug careers using heroin. This is largely to do with availability of other drugs, cultural norms and the negative social stigma associated with heroin in developed Western countries.¹ Most have experience of using at least one other drug, mainly cannabis, prior to trying heroin. In many cases, individuals reported having extensive experience with a wide range of drugs before using heroin. None of our qualitative interviewees reported that their first experience of an illegal drug was heroin. Like the online

Table 1 Early patterns of drug use described by the online sample

Early patterns of drug use	Number	(%)
Tried heroin first	10	(8)
Cannabis then heroin	14	(11)
Cannabis then dance drugs/psychedelics then heroin	35	(29)
Cannabis then dance drugs/psychedelics then cocaine then heroin	34	(28)
Dance drugs/psychedelics then cannabis then heroin	7	(6)
Other patterns	11	(9)
Early pattern not known	12	(10)

sample, most had moderate to extensive experience of other drugs – particularly cannabis, dance drugs and psychedelics – prior to trying heroin. This should not be taken as support for the ‘gateway’ or ‘stepping stone’ theory: people change their patterns of drug use for many reasons, and to say that one drug leads to another is to vastly oversimplify these changes. (For a comprehensive critique of the ‘gateway’ argument, see Witton, 2001.)

Trying heroin for the first time

Explaining why people decide to take certain drugs is a difficult task, reflecting the complex interplay between situational factors, individual traits and social values (see Parker *et al.*, 1998a). Many influences such as age, experience, personality type, drug availability, time and place, social stigma, peer networks and perception of risk are likely to have some bearing on the decision to try heroin. Our in-depth interviews provided some insight into this decision-making process.

Circumstances surrounding trying heroin

If an individual never stumbles upon a situation where heroin is available or accessible, the chances of them taking the drug are likely to reduce significantly. Thus individual circumstances will play an important role in determining whether some people try heroin. The majority of non-dependent and controlled dependent heroin users in our sample (44) appeared not to consciously seek out heroin, but rather encountered it largely by chance through friends. One of the ways this happened was through meeting a new partner who used heroin or had previous experience of heroin use.

For example:

... actually it was just one particular guy that I was going out with and he told me right from the start that he liked it and had used it before, and I was sort of inquisitive and he just got some one day and said, do you want a line? I said yes, knowing that it wouldn't, that I wouldn't get addicted, but just out of curiosity.

(Emma, aged 53, a controlled dependent user for 17 years)

Another means by which respondents came across heroin was by gaining access to new friendship networks. As one respondent noted:

I started getting in with another crowd who used to do heroin and, at first I was like, no, I don't want to start doing that ... in the end, I did end up having a smoke and it was like that's all right, but I used to do it just at weekends.

(Rachael, aged 35, a controlled dependent user for 12 years)

Some were introduced to heroin by friends bringing it into their social group. For example:

A good friend of mine who would go partying ... he started to get into it, he offered it to me and I wasn't interested but then ... it was the one I said I wouldn't do ... but my friend started using it and it was just because it was Christmas, at the time he said would you like to try some, and I just smoked some with tobacco and hash.

(Philip, aged 32, a non-dependent user for two years, previously dependent)

A small group of respondents (7) mentioned that they intentionally sought out heroin. These respondents purposefully gained access to heroin with a view to trying it for the first time. Respondents in our sample either did this alone

or in a group who had jointly decided to try the drug. The illustrations below provide examples of both scenarios:

The first time I came across heroin, well it was a friend, Jason, I used to get speed from ... people used to come and go, and from that I got to know this lad who was on heroin, a couple of lads who was on heroin. And then I asked, I approached them actually, they never approached me ... I did it with a group of four of us, none of us knew exactly what to do but ... we decided we was going to try this, and none of us exactly knew how to do it, we just knew they used foil and burned it on foil.

(Trevor, aged 25, a controlled dependent user for four years)

I suppose it's quite poncy really because it's like there's no need to do it apart from a desire to find out, to kind of, I got into it really through Burroughs and Ginsberg and beat poets and all that sort of ... yeah I went and bought it, in the same way that, I went and bought it in Soho, and that's what I've always done.

(Anthony, aged 33, a non-dependent user for eight years, with no previous dependence)

Three respondents also reported that, due to heavy consumption of other drugs, they first tried heroin to ease their 'comedown'. Two had been using cocaine and amphetamines for a number of days, and accessing heroin was relatively straightforward for them. The third had been out clubbing and had used a cocktail of dance drugs. He encountered heroin by chance at a post-clubbing party and used it in the hope that he would be able to function sufficiently well at work the following day. Another interviewee reported first taking heroin

as a form of self-medication. After experiencing a period of post-operative pain that prescribed pain-killers were unable to quell, the respondent's partner – who occasionally used heroin – suggested taking the drug as an alternative.

Reasons for trying the drug

As we have demonstrated, individual circumstances do play an important role in determining whether someone decides to take heroin. Many more people are exposed to the drug than actually try it, of course. It makes sense to presume that other influencing factors exist. We asked interviewees to expand on why they decided to try heroin.

Explanations tended to relate to the individual or the social environments in which people found themselves. Most interviewees provided at least one explanation. Thirty-five respondents felt that curiosity (30) or a sheer hedonistic approach to drug taking (5) influenced their decision making at the time. A further three respondents felt that trying heroin was compatible with a desire they had to behave rebelliously. As one interviewee stated:

I think a lot of my drug use is to do with rebellion ... I was brought up in a pub ... I didn't drink for very long because drinking was OK by my parents, my mum was an alcoholic, and I thought, OK, I want something, I'm going to do drugs and stuff because they were very anti-dope ... at the time, I didn't think that clearly at all, it was kind, oh, well, but when I think back about it, I think it was rebellion.

(Rebecca, aged 28, a controlled dependent user for ten years)

Occasional and controlled heroin use

Ten respondents mentioned how their first experience of heroin was prompted by instrumental, rather than hedonistic, purposes. These included: using heroin to ease the 'comedown' from other drugs, self-medication, alleviation of stress associated with high-pressured jobs, or using to block out particular life problems (a previous history of sexual/physical abuse was mentioned by two respondents²).

Five interviewees tried heroin because their experience of other drug use had not led to any of the negative consequences the media and health educators often highlighted. The attitude of this group tended to be, 'If cannabis and ecstasy failed to cause me the problems people said it would, then why should heroin?' This mindset is typified by this response:

I've been able to take these [other drugs] without any problems whatsoever you know, OK you might have a bit of a comedown the next day but you'd have a hangover if you were drinking. And I thought well we've been lied to about all of these yeah, they're not addictive, they haven't caused me any problems, in fact, quite the opposite, they've enhanced my life. So you know, what about the big one.

(Cameron, aged 32, a non-dependent user for six years, previously dependent)

Some research has shown how physical abuse or bereavement can form a 'critical moment' which, in order to cope, could lead some individuals into drug use (Allen, 2005). Six interviewees in our sample described how trying heroin corresponded with, or was related to, a 'critical' moment in their lives. For example, one respondent reported using heroin as a response to being imprisoned for the first

time. Two respondents talked about how their heroin use coincided with the death of a close family member. Another explained how the stressful nature of her job led to her first purchase of heroin, and that her subsequent use acted as a mechanism for blocking out abuses she had suffered as a child.

Other reasons provided by interviewees for trying heroin were related to social environment. A number of respondents (15) felt that continued exposure to heroin led to a reduced resistance to the individual and social barriers that prevented them from using the drug. They reported that heroin use became increasingly 'normalised' due to spending time with people who deemed it to be acceptable or that they began to question their beliefs and the popular image of heroin users as 'addicts' and 'criminals'. Only one interviewee highlighted pressure to conform as a reason for trying heroin. In some cases, however, it was clear that continued exposure to heroin created subtle pressure on the individual to take part in an activity undertaken by the core of their social group. Our findings support the argument that 'peer preference' – the process of selecting and gravitating towards like-minded people – provides a better framework for understanding why individuals begin to use particular drugs than explanations which focus solely on the often overplayed and misrepresented concept of 'peer pressure' (Coggans and McKellar, 1994).

Four respondents, having had previous opportunities to try heroin, described how witnessing or learning about alternative modes of consumption increased the degree to which they found heroin use acceptable. The following example illustrates how seeing somebody smoke the drug for the first time, and observing

non-dependent patterns of use, led one interviewee to reconsider their views about heroin use:

... at first I was like, no, I don't want to start doing that. So I'd still be doing Charlie ... so they were doing heroin, so they used to bang it up [inject] and I was like how gross is that? And then someone used to smoke it, I thought oh ... I think the needle to the foil was a big difference to me. I know it's the same, but I know I'm no different than anyone that bangs up, but to me it didn't seem as ... the people who were doing it didn't seem like the adverts, they seemed to control it. They'd do a little bit at the weekend or whatever.
(Rachael, aged 35, a controlled dependent user for 12 years)

Chapter summary

First use of any illegal drug and of heroin, on average, began later for this sample of non-dependent and controlled dependent users than it did for research samples of vulnerable young people. Reasons for trying heroin were complex and frequently dependent on circumstances relating to the individual and the social environment, and were often a complex interplay between the two. The process of peer selection provides a better framework for understanding why people began to use heroin than does 'peer pressure'. The majority of our sample described trying heroin because they chose to, not because they felt pressured or coerced into it. The fact that this group were keen not to abdicate responsibility for their early heroin use may tell us something about their individual characteristics and attitudes to drug use that make them better suited to controlling their heroin use.

3 Patterns of heroin use

This chapter examines patterns of heroin use amongst our sample of non-dependent and controlled dependent users. It begins by briefly looking at their previous patterns of heroin use, any experience of dependency or periods of problematic use, and current patterns of drug use (heroin and other drugs). We then go on to provide a typology of non-problematic heroin use. Finally, we examine who this group uses heroin with, where they tend to use the drug and why.

Previous patterns of heroin use

The online survey provides some indication of the diverse nature of heroin-using careers. Having provided respondents with a series of options, we asked which one best described the way they had used heroin over the years. Many different patterns of use were described, but most had either used a similar amount consistently (33 per cent), had periods of use followed by periods of abstinence (11 per cent), had experienced an escalation in use followed by a sharp decline (18 per cent), or had no consistent pattern of use (21 per cent). We asked respondents whether they had ever reduced their use in the past. Sixty-one per cent ($n = 75$) stated that they had. A few said they did this because they were becoming too dependent (10), were spending too much money on heroin (10), were using too frequently (6) or were neglecting parts of their life (3); most (40) mentioned a number of these reasons.

Our in-depth interviews ($n = 51$) provide a better indication of the different ways people go on to use heroin after trying it for the first time. Fourteen respondents reported having continued to use heroin occasionally, but having

never experienced a period of dependency. This group had used for between six months and 29 years, although most (12) had been using non-dependently for at least six years. Their using patterns did not always remain constant; some users had moved through periods where they used sporadically (perhaps once or twice a year) or were abstinent, to periods where they used more regularly (perhaps once or twice a month or even once a week) and vice versa, whereas others had used in a more regimented way.

The remaining 37 respondents, at some point during their using career, had continued to use heroin to the point whereby they became physically dependent on the drug. Experience of dependence differed widely: some became dependent very quickly, for others the process took a great deal more time. The length of time people were dependent on heroin also varied. A few respondents became dependent on heroin for a relatively short period (a few weeks) before reverting back to non-dependent patterns of use, which they maintained until the time of interview. This tended to happen early in a heroin-using career. Others experienced longer periods of dependency. For some, but not all of this group, dependency led to a variety of individual and social problems. These ranged from spending too much money on heroin and neglecting friends through to committing crime to help fund their use, reduced physical or mental well-being, imprisonment or relationship breakdown, and, in one case, a respondent described how his flat was taken over and turned into a 'crack house'. Those in the sample who had experienced episodes of dependent/problematic use (24) either continued to use dependently but did so in a controlled, less problematic way (2), or returned

to using non-dependently (22).

The final group of users in the sample are those who have used heroin dependently but whose use has always been relatively controlled and caused few significant problems. Our interview sample presented a range of varied 'heroin careers'. We would argue that it is incorrect to think about heroin careers as a series of preordained sequential stages, in which users progress from occasional through to problematic heroin use. Rather the historical accounts presented by interviewees point to the variation and fluidity of heroin-using careers; some individuals maintain consistent patterns of use for prolonged periods of time, whereas others can have different patterns of use at different times.

Current patterns of heroin use

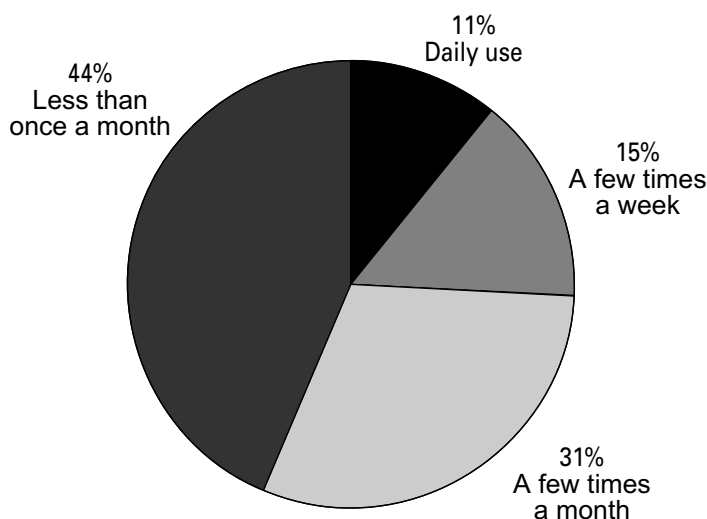
We asked those who completed the online survey to estimate how often they used heroin and how long they had been using in this way.

Figure 1 shows the frequency with which this group reported using heroin.

Three-quarters of the sample reported using heroin a few times a month or a few times every six months. Far fewer reported more regular use: 15 per cent used a few times a week and 11 per cent used on a daily basis. Using the frequency with which respondents reported taking heroin, we have grouped the sample into the following three types:

- 'Occasional' non-dependent heroin users (44 per cent) – individuals who use heroin on a six-monthly basis. This group used at least once every six months, but not as regularly as once a month. They use every now and then, 'when they fancy it', or when the situation arises.
- 'Frequent' non-dependent heroin users (46 per cent) – individuals who used heroin at least once a month, but in a non-dependent way. The group is made up of those who use a few times a month and a

Figure 1 Frequency of heroin use amongst the online sample



Occasional and controlled heroin use

few times a week, and whose use is still largely about leisure and recreation.

- ‘Controlled’ dependent heroin users (11 per cent) – individuals who were physically dependent on heroin, but who controlled and regulated their intake and avoided many of the problems typically associated with the drug.

The boundaries between the categories in this typology are far from rigid. The reality is that there is what others have described as ‘a continuum of heroin use’ (Shewan *et al.*, 1998, p. 231). The stages described above represent the early and middle part of the continuum where use is considered non-destructive and largely non-problematic. Obviously users can move either way along this continuum. For example, an individual may use occasionally for a number of months, then start to use more regularly in a non-dependent way, before reverting back to occasional use.

One way to measure stable use, and arguably the degree to which use is controlled and non-problematic, is to establish how long an individual has been using in a particular way. Our survey respondents reported maintaining a

stable pattern of use for between two months and 28 years. A large proportion had stable mid- (two to ten years) to long-term (ten years and over) using patterns, supporting the argument that their use was controlled and largely problem-free. Two-thirds (36) of those using occasionally had done so for over two years, and a number (22) had done so for over five years. Over half of those using heroin in a frequent non-dependent and controlled dependent way had done so for over two years. This provides some evidence to counter the popular belief that heroin draws users inexorably into dependence. Table 2 shows how long survey respondents had been non-dependent and controlled dependent users.

Evidence from our 51 interviewees also supports the argument that dependency is not an inevitable consequence of sustained heroin use. Table 3 shows how our sample fits into the typology described above and the number within each type who had previous experience of dependency.

Our interview sample included long-term (in excess of ten years) occasional and frequent non-dependent users who had never experienced dependency: one interviewee, for example, reported using intermittently for 29

Table 2 Length of time survey respondents reported using in an occasional, frequent non-dependent or controlled dependent way

Typology	Less than 6 months	6 months– 2 years	2–5 years	5–10 years	10 years plus	Total
Occasional non-dependent users	4	14	14	15	7	54
Frequent non-dependent users	9	18	15	8	6	56
Controlled dependent users	0	3	3	2	5	13
<i>Total</i>	13	35	32	25	18	123

Table 3 Type of user and previous experience of dependency within the interviewee sample

Typology	Previous experience of dependency	No previous experience of dependency	Total
Occasional non-dependent users	10	6	16
Frequent non-dependent users	18	8	26
Controlled dependent users	9	0	9
<i>Total</i>	37	14	51

years, another for 13 years and another two for 11 years without ever becoming dependent. The sample contains examples of sustained non-dependent use by previously dependent users (see case studies 1 and 2). For example, one interviewee reported using problematically between 1976 and 1985, but since then, and up until the time of interview, had used roughly once or twice a month. It also includes individuals who have been dependent on heroin for over 20 years, but have been able to maintain a stable, functional and relatively problem-free lifestyle (see case study 8). Patterns of use by the latter two groups mirror those of problem/dependent drinkers who have – either through treatment or on their own – managed to reduce, control or regulate their drinking (Sobell *et al.*, 1996). In summary, interviewees reported patterns of:

- mid- (8 out of 13) to long-term (5 out of 13) non-dependent use without ever incurring a period of dependence
- mid- (19 out of 22) to long-term (3 out of 22) non-dependent use after experiencing a period of dependent/problematic use
- mid- to long-term controlled dependent use (9)

- transition (they had recently used dependently or problematically) and new using (7).

Types of non-problematic heroin user

Below we examine our types of non-dependent and controlled dependent heroin users in a little more detail. In particular, we focus on:

- the money users spent on heroin/ amount of heroin used¹
- how often they used heroin (including space of time between using sessions)
- the number of days of consecutive use
- the mode of administration.

Occasional non-dependent users

The occasional non-dependent users in this sample ($n = 16$) reported using non-dependently for between six months and 13 years. Most placed strict limits on the amount of heroin they were prepared to use, which ranged from negligible amounts (under £5 worth) through to £20 and, in one case, £40 worth of the drug.² One interviewee also reported consuming a small amount when using heroin on its own, but having the potential to consume a great deal

more if using in conjunction with crack cocaine. Three of those who used approximately £20 worth of heroin reported doing so over a period of two days. One couple described how an unusual set of circumstances had led them to use the drug for eight days consecutively (this was one of three using sessions during the past six months). Whether this could be described as 'binge' use³ is debatable, as both respondents described using the drug in a sedate way, remaining functional and in total control throughout the eight-day period. Overall though, this group tended to use smaller amounts over a single evening or allotted period of time. The route of administration favoured by most occasional users was smoking (13), although one respondent reported alternating between snorting⁴ and smoking, one stated that they injected and another explained that they only smoked heroin in cannabis 'spliffs'.

The length of time occasional users reported leaving between using sessions varied. Some had used two or three times over the past year, whereas others had used two, three or four times during the six months prior to interview. Two users, both of whom had previous experience of dependent problematic use, described how they were careful to leave a set period of time between using sessions (two months). The remainder had less structured patterns of use: one respondent, for example, stated that she could use nothing for six months, then go through a period of using once a month before using less frequently again. Some in this group simply used as and when they felt like it. For others use was dependent on a chance encounter or other people providing an opportunity to use or get access to heroin.

Case study 1 Craig – an occasional non-dependent user

Craig was 28 and worked full time for a charity. He lived with his partner in a privately rented house. As well as using heroin occasionally, Craig also used cannabis a couple of times a week and occasionally MDMA powder, magic mushrooms and ketamine.

Craig's first experience of an illegal drug was cannabis at the age of 12. During his early teens, Craig began to use cannabis more regularly whilst attending parties and going to gigs. Around the age of 15 he began to experiment with LSD, which was followed a few years later, after becoming involved in the dance scene, by ecstasy. Having left the country to go travelling, Craig returned to England aged 20. Due to his limited finances he was staying with an old friend. His friend had begun using heroin and asked whether he would like to try some. Craig took up the offer. He stayed with his friend for around two months, at the end of which he was using a small amount almost every day, although he was not buying it for himself.

Craig felt that his friend's use was problematic and that his own use was heading in that direction, so he decided to move out. Ever since that period Craig had continued to use heroin on an occasional basis, although he chose never to buy it for himself. In the six months prior to interview he had used on two or three

(Continued)

occasions. He continued to use with the friend who introduced him to heroin:

When I go and visit him, not every time, but sometimes, he offers me a smoke, and sometimes I feel like it, and sometimes I don't.

Craig's use was determined by how he felt at the time and whether the drug was offered to him. Likewise the amount Craig would use, which was always relatively small, would also depend on what he was offered.

Frequent non-dependent users

Frequent non-dependent users ($n = 26$) tended to use fixed amounts as well. These amounts ranged from small quantities (around £5 worth) to three-quarters of a gram. This group reported using heroin between once a month and two or three times a week. Although some were careful about leaving set periods of time between using sessions, others mentioned that the frequency with which they used often fluctuated. Amongst this group regularity of drug use appeared to be reliant on how the individual felt at the time, along with ongoing life commitments, their financial situation and whether they considered their current use to be too frequent. Thirteen respondents indicated that sometimes they would use on consecutive days. Of these, two respondents self-defined as 'binge' users. Both reported using half a gram over two days. However, one respondent described using heavily on the first night and then using what was left the following day, whereas the other respondent described spreading his use evenly across two evenings. The majority of this group

smoked heroin (20); four interviewees reported injecting (three had experienced bouts of dependent problematic use) and two indicated that they alternated between injecting and smoking.

Case study 2 Claire – a frequent non-dependent user

Claire was 54 years of age. She owned her own home and worked part time in the health sector. Claire was privately educated. In addition to heroin, Claire regularly smoked cannabis (daily use) and occasionally used LSD, but did not drink alcohol.

She first tried cannabis aged 16 before dropping out of mainstream society to live a hippy lifestyle on a houseboat where she continued to use cannabis, pharmaceuticals and LSD. Claire had a son at 18 and married soon after. Almost immediately they split up. Claire then met a new partner who injected heroin. She reported being particularly depressed at the time. Her new boyfriend mentioned that heroin might help alleviate some of her depression. After a while she decided to try it, allowing her boyfriend to inject the drug for her. As Claire explains, the stigma associated with using heroin was different during the late 1960s and 70s:

I think by then I'd tried so many drugs it was just another sort of drug. I didn't really think seriously about it, and I suppose there wasn't the same sort of explosion as there is now, or fear around it

(Continued overleaf)

so much. It was still considered quite romantic ... it wasn't considered the sort of scummy drug it is now.

Claire stated that heroin took away her depression, relaxed her, and made her feel in control. She continued using the drug occasionally before splitting up with her boyfriend. Claire then moved in with a friend – also a single parent. They began to use heroin daily. Both had ‘family’ money, which enabled them to finance their use. Both felt able to cope with raising their children and felt in control of their use. Eventually, however, pressure from their respective families and social services led to a short detoxification in a residential rehab. For a number of subsequent years Claire flitted between drugs and in and out of small bouts of dependency.

In 1976, Claire met and married her second husband. He was also a heroin user. They maintained a daily habit from the start of their marriage through to 1985. Claire had family money and her new husband had a substantial trust fund, thus financing their dependency was not a problem. Since 1985 Claire had used heroin non-dependently (19 years). Over this period Claire’s use had fluctuated between not considering it for a few months through to using once a month or even once a week. At the time of interview, Claire was using around once a month. She used with her husband and a group of friends who used in a similar way.

Controlled dependent users

Controlled dependent users tended to be daily heroin users (7 out of 9). This group used between 0.1 and two grams per day. They took heroin in a variety of ways: three smoked, a couple snorted, and a couple alternated between smoking and snorting. One person alternated between smoking and injecting, and one just injected the drug.

All users reported using a set daily amount, and most stated that they used in a particularly structured way and had done so for between four and 30 years. Three respondents, for example, stated that they tended to use a set amount of heroin in the morning, afternoon and evening. As Emma explained:

I just do one line in the morning and one in the afternoon and another in the evening and that keeps me together for the whole day ... I suppose it's self-regulation in a way.

(Emma, aged 53, a controlled dependent user for 17 years)

Having used heroin in a relatively problem-free way for the past 30 years, one controlled dependent user described how she ‘snorted’ one line of heroin (worth approximately £10) per day as and when she felt the need. Another respondent, who used two grams of heroin per day, described using a small amount every couple of hours throughout the day. This may seem sufficiently large an amount to qualify as uncontrolled use. However, this respondent had a stable pattern of use and supply, and was successfully working in a demanding profession and running his own company. He had been using heroin with few significant problems for 30 years. A dependent couple also described how they used ‘street methadone’⁵ to manage their dependencies whilst taking a short break from using heroin.

Case study 3 Rebecca – a controlled dependent user

Rebecca was 28 years old. She was employed as a shop manager in the sex industry. Although this was a part-time job, it paid well. Rebecca also did voluntary work with young people for her local housing office. She lived on her own in a flat rented from the council.

She began smoking cannabis with school friends aged 14. Her drug use progressed quickly. By the age of 15, Rebecca began going out to clubs and using ecstasy, LSD and cocaine. By the time Rebecca was 18, she was going clubbing every weekend using 'lots of Class A drugs'.

Rebecca first tried heroin at 19 when it was offered to her by her boyfriend at the time. She resisted trying it for a while, but relented citing two reasons. The first was that watching her boyfriend take heroin without incurring any major problems broke down many of the barriers that guarded against trying it. The second reason she cited was rebellion: her parents ran a country pub (her mother was an alcoholic) and they were very anti-drugs. Rebecca used heroin for a year. She began using £5 worth, which progressed to £10 worth a day. Her relationship then finished and she stopped using heroin. During this time she successfully completed a degree.

A year and a half later, Rebecca encountered the opportunity to purchase and use heroin again. Initially she began using at the weekends, especially as a

'comedown' after using stimulants whilst clubbing. After locating a more convenient supply, she soon began using on a daily basis (the only time she stopped thereafter was for a year and a half after being the victim of a rape attack).

Rebecca has worked and travelled throughout her using career. At the time of interview, she used about half a gram a day, which she injected. She used a quarter of a gram in the morning and a quarter of a gram in the evening. At the weekend Rebecca also used cocaine which, whilst at work, she injected with heroin. However, after work (Friday and Saturday nights) she socialised with a group of friends where injecting was perceived somewhat negatively. This group of friends also used heroin in a controlled way. They were an experienced and stable group whose weekend use was social and about enjoying one another's company, as well as enjoying the effects of the drug – the sole purpose was not 'getting wasted' or to chase oblivion.

Other drug use

Other illegal drug use was fairly common amongst our sample of non-dependent and controlled dependent heroin users. Analysis of data from the online survey shows that, with the obvious exception of heroin, alcohol and cannabis were the drugs most likely to be used in the month prior to completing the survey. Just over 50 per cent of the sample had used

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prescribed opiates or powder cocaine, around 40 per cent reported using amphetamine, ecstasy or methadone, and 30 per cent had used crack cocaine in the previous six months. Figure 2 shows the use of other drugs in the month and six months prior to completion of the survey.

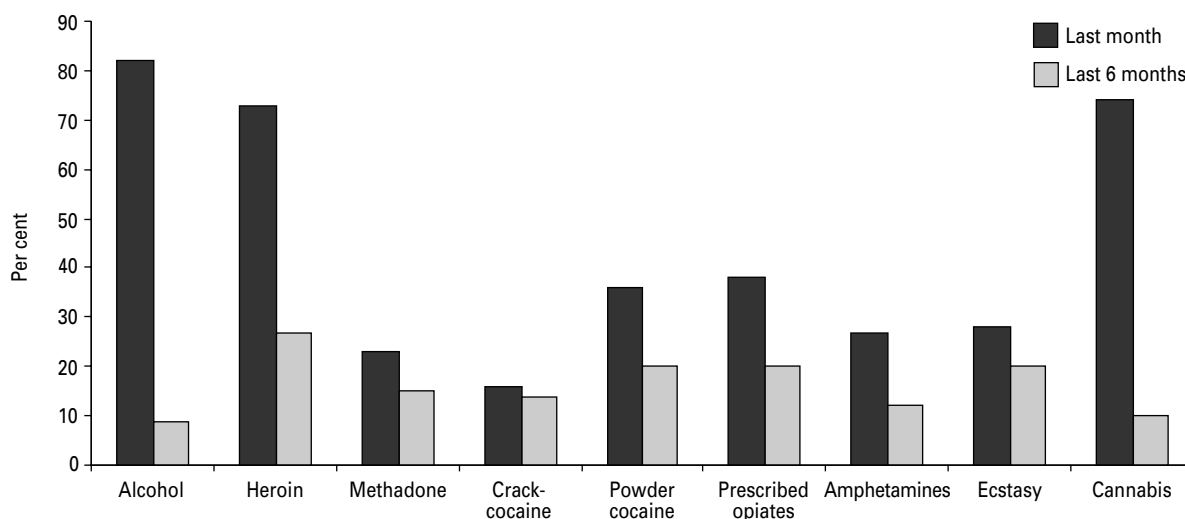
Regular use of other drugs was also fairly common amongst our sample of interviewees, although less evident amongst the group of controlled dependent users. Three controlled dependent users, for example, reported just using heroin. A further two stated that they used methadone regularly, but no other drugs (see below for a discussion about methadone). Three indicated that they occasionally used cocaine or cannabis, and Rebecca, the previous case study, stated that she used ecstasy occasionally and cocaine at the weekends. None reported using crack cocaine.

Use of dance drugs, alcohol, cannabis, crack cocaine and psychedelics were more common amongst non-dependent users, although there were no discernible patterns of other drug use

amongst occasional and frequent users or between those who had previous experience of dependence and those who did not. However, our sample of interviewees had extensive experience of a range of different drugs. It is likely therefore that most interviewees had experimented sufficiently to establish which substances they preferred to use on a regular basis. Interestingly a number of respondents described how they perceived the effects of cannabis (although less intense) to be similar to those produced by heroin, which may go some way to explaining the popularity of cannabis amongst this group.

One occasional and one frequent non-dependent user described their use of other drugs to be problematic. Both cases are different, but worthy of mention. The first relates to Sharon, a daily crack cocaine user. Sharon's use of crack cocaine fluctuated depending on how much money she had. The minimum amount she used was one £10 rock per day. Sharon funded her use through benefits

Figure 2 Use of other drugs in the month and six months prior to completing the online survey



and occasional dealing and by committing fraud and deception. However, she used heroin only when binging on crack, which tended to be once a week, as this enabled her to manage the mental and physical discomforts that arise when 'coming down' from heavy crack cocaine use. Sharon's heroin use was carefully planned and served a particular purpose in the context of her problematic crack use. It is likely that Sharon is representative of a much larger group of users who occasionally use heroin to manage their 'comedown' from crack cocaine.

On the other hand, Dave, who was a successful writer, had used heroin on a couple of occasions during the past six months. Dave was dependent on alcohol, although he was aware of the problems this caused him and had set about regulating and managing his use. Over the years he had experienced periods of dependent cocaine, alcohol and tranquilliser use. However, Dave had used heroin non-dependently for the past nine years without experiencing dependency or any of the problems associated with it. Both Sharon and Dave demonstrate how individuals can be problematic users of other drugs, but still use heroin in a relatively controlled and problem-free way.

Use of methadone

A fifth of interviewees (10) reported being regular users of methadone. Most of these users (8) were not dependent on heroin, but were dependent on methadone. Five respondents received a NHS prescription, two were in receipt of private prescriptions and three bought street methadone. All ten respondents used methadone in slightly different ways, although the drug clearly played an important role in

enabling each of them to manage their heroin use. One couple, for example, used heroin only on Friday and Saturday nights, but had a private maintenance prescription for methadone that they used throughout the week (they had been using like this for over ten years). This enabled them to enjoy the 'high' from heroin at the weekend whilst allowing them to get on with work and other activities during the week without worrying about withdrawal. Three of those on NHS maintenance prescriptions tended to use heroin and methadone in a similar way: they used heroin as and when they could afford it or at the weekends.

Two respondents had methadone scripts, but chose not to use them on a daily basis. One reported taking methadone on Sunday and Monday to ease him back into 'normal' everyday life after using heroin over the weekend. The other interviewee, Clive, used heroin at the weekend only. He had a history of dependence, which contained periods of problematic use. At the time of interview, he was employed and enrolled on a vocational course. During the previous 12 months, his financial resources had been somewhat limited so he started using street methadone during the week to help save money and to be 'clear-headed' for his course. Clive was disinclined to engage with treatment services or his local GP as he was fearful of being known and labelled a heroin user and, apart from funding, considered his current use not to represent a significant problem.

Other respondents indicated they would use street methadone if they began using too much heroin and wanted to cut down, or could not afford to buy it. Rebecca, for example, described using street methadone if it was getting towards

the end of the month and she had spent her wages, needed to pay a large bill or if the quality of heroin was poor. Case study 4 describes how street methadone enabled one respondent to control his heroin dependency.

Case study 4 John – a *controlled dependent* heroin user

John was 41 years of age and worked as a computer engineer. He owned his own home and lived with his partner (also a controlled heroin user).

Between the ages of 16 and 21 John experimented with cannabis, speed and LSD, which he used recreationally with friends. John first tried heroin when he was 21. At the time, John was a DJ and his brother was in a band. They were part of a local party scene. Within this group there was a smaller subgroup of heroin users. Initially John was wary of them and of the drug, as he had seen members of this group being physically sick, and felt that using the drug would be unpleasant. He was also aware of the ‘bad press’ that accompanied heroin. One evening John, who described being very stoned, was offered the opportunity to try some. Out of curiosity, he decided to do so. He then began using occasionally. John enjoyed using heroin and began buying the drug himself. Soon after he met a new girlfriend and started using with her. Very quickly their use started to spiral out of control. John’s use became chaotic and problematic – he dropped out of university, lost

everything that he owned, acquired substantial debts and ended up in hospital with thrombosis. After completing three in-patient detoxifications, John reverted back to using occasionally. Since this point (aged 24), John has slipped in and out of dependency, but has always since considered his use to be controlled.

John used heroin between four and six times a week. He used in the evening with his partner or on his own, and smoked up to a gram of the drug. He had a busy and demanding professional life. John was well aware that using heroin whilst working could lead to a number of potential problems. To overcome this, John used street methadone whilst at work and on the days he chose to have a break from using heroin. John described this pattern of use as being a fully integrated part of his life.

Heroin-using environments

The ‘setting’ or an individual’s using environment plays an important role in defining how they think about their drug use. Various authors have also emphasised that who an individual uses with, where they use and the circumstances surrounding their use are important factors in establishing controlled patterns of drug use (Zinberg, 1984; Grund, 1993; Decorte, 2000).

Our interviewee sample reported using with a range of different people. Most used on their own (15), both on their own and with friends (12) or just with friends (12). The remainder

used heroin with their partner and/or friends (5), just with their partner (4), on their own or with their partner (2) or on their own or with someone who was largely unknown to them (2). The two respondents who reported, on occasion, using with individuals relatively unknown to them did so with *Big Issue* sellers⁶ who had purchased heroin for them. Neither respondent viewed this behaviour as particularly dangerous or problematic. Despite this, the majority of interviewees were careful to only use heroin with those they knew or felt comfortable with.

Those interviewees who only used heroin with a particular set of friends tended to do so in a thought-out and structured way; they had a set pattern of use that members of the group felt comfortable with. Such situations are typical of those described by Becker (1963) and Zinberg (1984) where rules about what is acceptable and what is not evolve within the group setting and therefore create boundaries and barriers that help individuals maintain control of their use (for a further discussion see the section on using rules in Chapter 4). Jane, an occasional user, described using heroin in exactly this way. She only ever used with two other female friends, and only after an evening of clubbing. The decision to use was discussed beforehand, which provided an opportunity for each member of the group to opt out. Likewise the amount they used, the way they used it and how often they used had remained constant for 12 months. Their using pattern and environment were clearly defined and aimed to ensure they felt comfortable and in control of their use.

Others used with a variety of friends, and sometimes in different circumstances. Claire, for example, described how she used occasionally

with her husband and a group of friends:

I use with my husband. I have a couple of friends that I use with as well that use the same way as me. They've got past histories with addiction but they sort of manage to do it like me now as well. So there are probably about five of us ... we go to their house or my house ... we sit down, smoke some heroin, have a cup of tea, listen to music, chat and be sociable.

(Claire, aged 54, a non-dependent user for 17 years, previously dependent)

Most interviewees tended to gravitate towards those who used in a similar way. (See below for a discussion about avoiding those 'immersed' in the heroin subculture.) However, there were a few non-dependent users who appeared happy to take heroin with friends who were dependent or problematic users. As Ian, who used heroin on his own and with others, explained:

Normally I buy a gram and then share it with one or two people. I'd always keep half for myself and give the other two a quarter or whatever. Not give it, but they chip in ... I've sort of got two or three people that don't know each other, but one person is like me, he'll do a bit every now and again, another person is a chaotic user and he's on it every day anyway, but I know that if ever I want to use with somebody I can always go to him.

(Ian, aged 33, an occasional user for 11 years, with no previous dependence)

All but two of the sample used heroin in his or her home or the home of a close friend. Often these environments were described as safe and relaxing. A number of respondents stated that they used – or at least sometimes used – on their

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own. This group tended to comprise controlled dependent users and those with previous experience of dependency. For controlled dependent users, taking heroin at home on their own was simply a by-product of the degree to which heroin was an integral part of their life. Rachael, a controlled dependent user for 12 years, illustrated this point:

... perhaps in the evening there's more people who come round who are doing it, so it's more of a social thing in the evening. But the other parts, it's just getting up and doing it, like brushing my teeth, I suppose.

(Rachael, aged 35, controlled dependent user for 12 years)

Lone use by non-dependent users, in most cases, tended to be planned and organised around a set of using rules (see Chapter 4). Mary described how she carefully organised and concealed her occasional use from those around her:

It's like phone a friend and say I'm going away, looking after a friend she's not well, the phone will be off, don't worry I'll call you when I get back and all of that. And I'm in my flat. So the phones are off the hook, I've got videos, got numbers for takeaways if I feel like eating, but I don't usually ...

(Mary, aged 42, a non-dependent user for eight years, previously dependent)

Three controlled dependent users and one non-dependent user described, on occasion, using heroin in a public space. All three controlled dependent users reported 'snorting' the drug at such times, which enabled them to use discreetly without drawing unwanted

attention. Only one non-dependent user described taking heroin in a potentially dangerous situation. Victoria infrequently used heroin in the stairwell of a block of flats. Although she had been using occasionally for four years, this behaviour replicated the way she often took heroin whilst using problematically. She stated that sometimes she enjoyed reliving the 'sleaziness' and the feeling of 'not caring about anything'.

As well as using in a safe, comfortable and relaxing environment, various interviewees mentioned that trusting those present when using was important. Many associated the temptation to use more regularly and a lack of trust with those further 'immersed' in the drug world or heroin subculture. Where individuals had previous experience of problematic use, they often talked about staying away from the environment and people they had formerly used with. Others talked about avoiding the wrong sort of people, particularly those who were perceived to be out of control and involved in criminal activity. As Rebecca stated:

It's more of a social thing in London, yes, because when I'm here on my own for five days I try and stay out of the drug world as much as possible ... it's very easy to get drawn deeper and deeper into spending more and more money on it, life gets a bit more dodgy round the edges, so I try and keep out of the whole world here and only spend time with non-drug-taking friends and family ... the people I know in [place Rebecca lives], they are my age and younger and they're all running around shoplifting and stealing cars. I'd just rather keep away from them because I don't want to go there ... people [in London] don't want to get out of their heads, out of control. I think

they enjoy being high together. It's a nice feeling to be high amongst people who are on the same level.

(Rebecca, aged 28, a controlled dependent user for ten years)

What do users enjoy about their current use?

People use illegal drugs because they can provide enjoyable experiences. Heroin is no different to any other drug in this respect. However, the effect heroin has on the body depends largely on tolerance levels and on the severity of dependence to the drug. When asked about what they enjoyed about their current use, it came as little surprise then that non-dependent and controlled dependent users provided different responses.

Three key themes emerged from non-dependent users' descriptions of their enjoyment. The first was the 'buzz' or the physical feeling generated by heroin. Often this was described as a feeling of warmth and comfort; a few interviewees verbalised this as being wrapped in a ball of cotton wool. Most occasional users also described enjoying feeling 'calm', 'mellow' and 'relaxed'. The third element of enjoyment involved respondents feeling disregard for any stress, concern or worry they might have had. This sense of 'not caring' or 'not having to worry' occurs largely because heroin inhibits the capacity to respond to situations emotionally. Alvin, for example, described:

... just sitting there nice and mellow, that's part of my enjoyment of the drug now, I find it's relaxing ... it takes away whatever worries I've got,

whatever thoughts, they're just thrown out, and I'm not bothered.

(Alvin, aged 35, a non-dependent user for three years, previously dependent)

Contrary to popular belief that heroin renders people socially defunct when they have just used, a few users indicated that they particularly enjoyed the chatty, sociable, almost stimulant-like effect that use of smaller amounts of heroin can generate. Two respondents also reported enjoying hallucinogenic and visionary experiences whilst using heroin. As Anthony explained:

It's kind of the visionary quality of it ... I sort of visualise stuff, you get this kind of ... you're not actually physically seeing it in the room but your getting a kind of transportive element and ... I like it for that kind of opiated dreamlike quality.

(Anthony, aged 33, a non-dependent user for eight years, with no previous dependence)

In many ways, using heroin non-dependently was simply an opportunity to have fun, 'switch off' or take some time out to relax, although it tended to be one option amongst a range of others for doing this. This point is exemplified by Andrew who explained that heroin was one of a number of different drugs he used recreationally:

I don't get a craving but I sort of think oh I fancy a bit of gear [heroin], I fancy a smoke and I will do. It's the same with weed, you know, it's like the other drugs really. Just sometimes I fancy a bit of ketamine or some MDMA or gear really ...

(Andrew, aged 33, a non-dependent user for 13 years, with no previous dependence)

A small number of interviewees also mentioned that part of their enjoyment stemmed from the fact they could use heroin yet remain in complete control of their actions. As Tim explained:

... you've got that protective shell around you ... and you're not out of control, it's not like you're falling about and you'll never remember anything and you're making a fool of yourself ... it's a very controlled feeling of relaxation.

(Tim, aged 45, a non-dependent user for seven years, previously dependent)

Controlled dependent users, on the other hand, did not enjoy using heroin in the ways described above. Use amongst this group was primarily about avoiding withdrawal and maintaining a sense of normality rather than achieving any sort of euphoric 'high' – that is not to say this was impossible or did not happen. However, some interviewees did describe benefits of different sorts. Two reported that they found heroin's calming effect beneficial as it counteracted a tendency towards hyperactivity, which enabled them to function in more productive ways. Five respondents also mentioned that, to varying degrees, it aided relaxation; one respondent likened it to simply having a few glasses of wine each evening. Despite this, it was clear that controlled dependent users did not gain the same level of pleasure as non-dependent users.

Chapter summary

In this chapter, we have presented findings that contradict some popular assumptions about heroin. We have demonstrated the existence of subgroups of heroin users who have been using

the drug non-dependently or in controlled, stable and largely problem-free ways for prolonged periods of time. Our study cannot give any indication of the size of the population of non-dependent or controlled dependent heroin users; nor does it imply that heroin use is free of serious risks associated with dependence. However, it shows that heroin use does not inexorably and in every case lead to dependence; and it also shows that problem use, or uncontrolled use, is not an inevitable outcome of dependence on heroin.

This chapter has shown heroin use and heroin careers to be fluid and hard to define. We have provided examples of users who have switched from problematic or uncontrolled heroin use to stable, controlled or non-dependent using patterns. The idea that some people can move from uncontrolled to controlled patterns of drug use has important implications for treatment services that target chaotic users. Not all chaotic users want or are ready to stop taking heroin, thus for some people a more appropriate treatment goal might be controlled heroin use. Approaches of this sort are commonly used by services tackling problem drinking.

One of the characteristics of our sample of non-dependent and controlled dependent heroin users was the care they showed in choosing where they used and who they used with. This allowed them to use heroin in safe, comfortable and relaxing environments, which helped to create the conditions in which controlled use was possible. By keeping their use relatively hidden and not associating with those further immersed in the heroin subculture, respondents considered themselves to be different from uncontrolled users, 'junkies'

and 'addicts'. These factors helped interviewees to avoid being labelled, protected their self-image and, ultimately, contributed to them rejecting the 'problem' user or 'junkie' identity.

For many respondents in our sample, rejection of the 'junkie' identity played an important role, albeit it subconsciously in many cases, in facilitating controlled heroin use.

4 Regulating and controlling heroin use

The experience of our respondents shows that dependency is not an inevitable consequence of regular heroin use nor is uncontrolled use an inescapable consequence of dependency. Some people can use heroin in a non-dependent way for long periods of time, and others are able to control and regulate their dependency. How are some people able to use heroin in a relatively problem-free way, whilst others are not? This chapter aims to provide some answers to this question, drawing on our in-depth interviews.

We start by examining the components of control, outlining how the following factors – which are by no means mutually exclusive – helped respondents regulate their heroin:

- patterns of heroin use and using environment
- the application of ‘using rules’
- life structures and commitments
- attitudes and individual characteristics
- access to heroin
- what respondents expected from heroin (i.e. what sort of feeling and effects)
- previous experience of heroin use
- external pressures.

We then present two case studies that show how these control mechanisms were actually used. Finally, we discuss how respondents reacted or might react when situations arise that test their mechanisms for control.

How is control achieved?

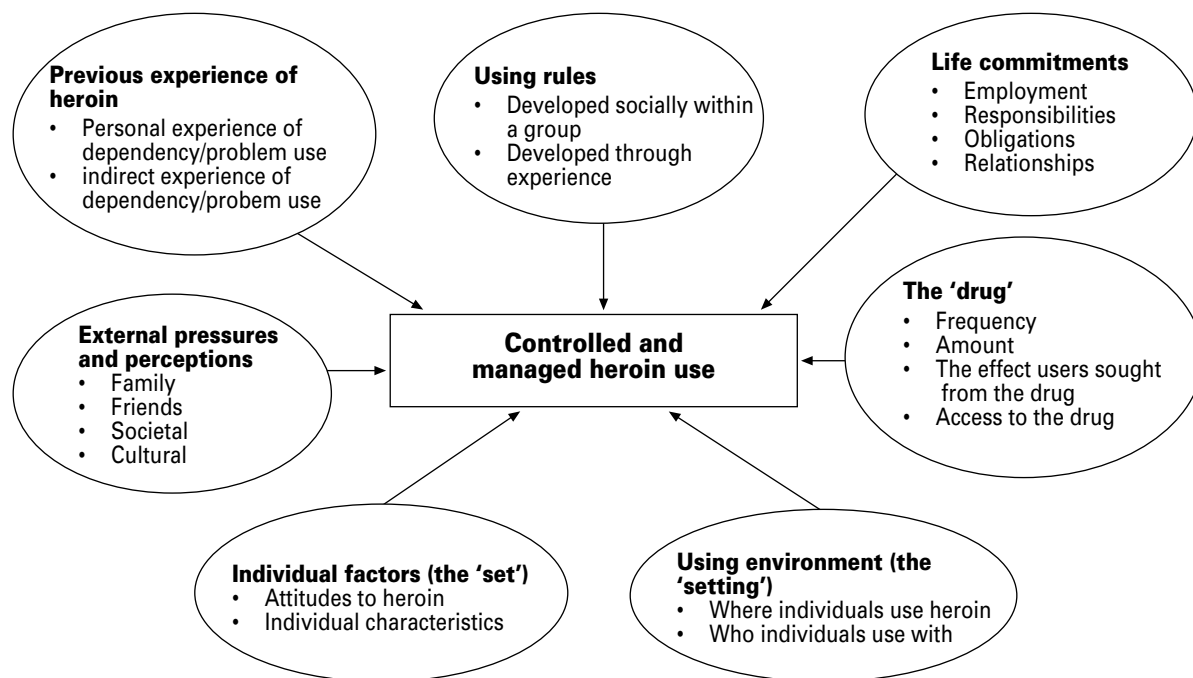
Like other researchers, we found that the ‘drug’ (the pharmacological effect of the drug), ‘set’ (an individual’s mindset whilst using the drug and individual characteristics) and ‘setting’ (the social environment in which the drug is used) all provide important elements of control. We also found other factors to be important, including: frequency and quantity of use, access to heroin and the effect users sought from the drug, combining use with normal everyday activities and commitments, the views of others (friends, family and wider societal pressures), and the influence of previous experience. Figure 3 highlights these components.

There is no magic formula for controlling heroin use. Rather, it is a complex process achieved by multiple means. The components of control presented in Figure 3 were described as important by some respondents and not by others. Much depended on the individual, how they used heroin and their personal situation.

Patterns of current heroin use and using environments

The previous chapter highlighted how most occasional and frequent non-dependent users set limits to the amount of heroin they used at any one time (which tended to be relatively small) and how some users were careful to ensure a period of time between each ‘session’ of heroin use. We also noted that using a set daily amount at particular points during the day was a characteristic of the group of controlled dependent users. Overall then, we found that stable use and careful planning and organisation surrounding the frequency and amount of heroin used were important aspects of control.

Figure 3 Components of controlled and managed heroin use



We should highlight the importance of using environments. Nearly all non-dependent and controlled dependent interviewees reported using in an environment that they deemed to be safe and comfortable – whether that was with friends or alone. Most avoided contact with those whom they considered to be uncontrolled users of heroin and those involved in criminal activity (this issue is explored further in the section about access to heroin). As we shall explain below, using networks also helped to negotiate and create boundaries and rules to establish controlled patterns of use.

Applying 'using rules'

Applying rules to our everyday behaviours is not unusual. Many of us have rules about when and how much alcohol we drink, for example drinking only in the evenings or at weekends.

Developing a set of conventions for heroin use is not dissimilar.

As we have shown, interviewees had rules about how much and how often they used heroin. They also applied other rules to their use. This conscious and subconscious rule making helped to set boundaries within which responsible and controlled use could occur. Breaking a using rule could be construed as the beginning of a shift away from control and towards increased heroin-related problems, as is discussed below in the section about testing control mechanisms. However, this does not mean that using rules were rigidly fixed for life; rules may change as an individual's learning about heroin use develops over time or if an individual moves to another peer network that employs a different set of using conventions. Changes to how a person conceptualises the

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boundaries of acceptable use may strengthen some people's control mechanisms, but may push others closer towards uncontrolled use.

'Using rules' were more common amongst occasional and frequent non-dependent users. Some had a set of loose rules that helped to shape their use. Others had stricter and more prescriptive rules. Although often applied in different ways, there were a number of rules that were commonly reported by our interviewees. These included:

- not injecting heroin
- not buying heroin if they could not afford it
- not using heroin for more than two/three days consecutively
- being in the right frame of mind before using heroin, i.e. not using it to escape from problems in life but using for enjoyment
- buying a set amount and not buying any more once that had run out.

This was not a shared set of using rules. Rule making was very much dependent on the individual, their using environment and experience. For example, most non-dependent and controlled dependent users felt that not injecting was conducive to maintaining problem-free use. However, three respondents reported that injecting played a part in enabling them to control their use. For example, Joe had never experienced a period of dependency and had been using heroin sporadically for the past seven years; he injected only once per using session, as that enabled him to use the heroin in one hit and prevented him using more:

... like I was saying, just get it all in, then I can sit back and enjoy it then. I think when you're smoking it, because it's there all the time, you're going backwards and forwards to it ... I know some people that smoke it and they smoke, then they'll pile some more on there. It seems like they're getting through tons of it.

(Joe, aged 31, a non-dependent user for seven years, with no previous dependence)

For non-dependent users, one of the main purposes of employing using rules was to avoid becoming dependent. Controlled dependent users, on the other hand, did not employ prescriptive systems of rules, although they did have rules and rituals that helped to maintain stable patterns of use. The only using rules mentioned by this group related to financing their dependency. Most indicated that if they did not have the financial resources to purchase heroin, then they would begin to reduce the amount of heroin they were using. As Rachael explained:

I've been selling a lot of my art work and I've been doing a lot of waitressing ... I do struggle, so sometimes I have to, say I think I'm not going to have enough money for the next day, I'll have to take a bit less and lower my doses down so I don't run out of gear ... I'd have to do a bit less and perhaps maybe feel a little bit uncomfortable, but I wouldn't be sick.

(Rachael, aged 35, a controlled dependent user for 12 years)

How using rules are learnt

Using rules are developed within a group environment or as an individual's experience of heroin use increased. Case study 5 describes how Philip developed his using rules, socially, amongst a small group of close friends.

Case study 5 Philip – an occasional non-dependent user

Philip had previously been a dependent user. However, he had not used heroin regularly for three years prior to being interviewed. He 'got off' heroin on his own without any help from services. After a year of being abstinent, he met two old friends who were both using heroin occasionally. One of these friends (who was also interviewed for this study) had, like Philip, a previous history of dependent use. Philip described them as being 'very sensible with it'. He felt that his perspective on the drug had changed and he felt sufficiently in control to try the drug again. Since this point (two years ago), Philip had been using heroin roughly once every couple of months.

Philip only ever used heroin with these two old friends. Having seen his friends using 'sensibly', Philip began to use heroin in the same way that they did: a maximum of £20 worth no more than once a month; using it all in one evening so there was none left for the following day; not having direct access to heroin; only ever using it for the purposes of having a good time, not as a mechanism for escape; and only ever using when he could afford it.

Undoubtedly Philip's previous experience played some role in enabling him to control his use. However, both of Philip's friends were applying the same rules to their use prior to him joining their group.

There were other examples of socially negotiated and learnt rules. Jane, for example, only used heroin with particular friends after an evening out clubbing. The boundaries for her had been developed and were governed by this group. We also interviewed a couple who had been together for five months and were clearly in the process of learning and negotiating the rules that defined the boundaries of their occasional use. However, the following case study describes how Joe used an array of rules developed mainly through his individual experience.

Case study 6 Joe – a frequent non-dependent user

As mentioned above, Joe had never experienced a period of dependency and had been using heroin intermittently for seven years.

Joe had a fairly prescriptive set of using rules. He only used around £5 worth of heroin at one time, which he injected in one go, so he was able to get on and enjoy the effects of the drug. He never used alone, only used at the weekends, did not buy or have direct access to heroin, had a minimum of two weeks between using sessions, pre-planned his use, and always ensured that use was about pleasure and enjoyment and not escaping from life problems, as he stated:

I just kind of maybe assess myself really before I'm using because it takes everything away and there's been times when I've wanted to use it as

(Continued overleaf)

a tool of abandonment, and that kind of scares me. I feel quite fearful ... I mean it's great to have a little taking away, but at the end of the day you've got to deal with it [life problems], and it [heroin] stops you from doing that. So don't do it.

Although Joe used heroin with different friends in different circumstances (he never consistently used with one social group), most of his using rules appeared to have been developed individually through experience. The amount he used corresponded to that which he felt was his natural limit. The reason he injected was because he felt smoking encouraged additional use; he had used this way previously and had continued to witness friends smoke what he perceived to be large amounts. Smoking also made him nauseous, which undermined the enjoyable side of heroin. Thus he preferred to inject heroin. His experience led him to believe that those who used heroin problematically did so to blot out things that were wrong in their life. As a result of this perception, Joe was careful only to use heroin for the purpose of enjoyment. Many of Joe's other rules were based around common-sense decisions. In Joe's case, learning through experience appeared to have a much stronger influence than learning rules from within a group.

Life structures and commitments

Obligations, commitments and responsibilities are influential in determining patterns of behaviour. In many ways, life commitments and

responsibilities provide the focal points around which we mould our everyday lives. A common theme amongst our sample of non-dependent and controlled dependent users was that they all had life structure and commitments, albeit to varying degrees.

Some non-dependent users – particularly those with no previous experience of dependency – described having much to lose. Particular concerns included employment, partners, college courses or family. For example, Joe, the previous case study, explained how the threat of dependency and perceived losses he might incur encouraged him to use carefully:

I work, I've got a flat to maintain and all the rest of it. I enjoy going out, I like to go out for meals and stuff, I like the nicer things in life and you can't do that if you're a full-time heroin addict. (Joe, aged 31, a non-dependent user for seven years, with no previous dependence)

A number of non-dependent users also described how their life commitments enabled them to review and maintain control of their use. Jason, for example, described upping his use (he began using on two consecutive days per week) and the effect this had on his work and partner, which led him to take a break:

It does have a knock-on for my work, because going in strung out is actually the worst bit because it's like having a cross between flu and a hangover for two days and you're not really good for anything. And if you do that for too long, people are going to start noticing at work. Even in my job [computer programmer]. And again my girlfriend was starting to go, 'This is out of order, I wanted to go out and you're sat on the sofa

staring into space.' And so you get ultimatums from there as well, so it's like okay, time for a break.

(Jason, aged 32, a non-dependent user for nine years, with no previous dependence)

Those with previous experience of dependency appeared to place greater importance on everyday activities. They often discussed the importance of employment or education and the focus this provided. As Jake explained:

I feel that there's an implicit pressure to control my use because I'm under obligation to my partner; we've got bills to pay and financial obligations and my income is very limited. So these obligations conflict with my drug use.

(Jake, aged 41, a non-dependent user for two years, previously dependent)

Below Jane talks about the importance of gaining a new focus and about her family and college course:

The life I've got at the moment, the job I'm doing, the career opportunities I've got, I won't mess it up, and the life I've got at home with my daughter, I won't mess it up for anything.

(Jane, aged 23, a non-dependent user for one year, previously dependent)

Jane was typical of a number of other current non-dependent users with recent previous experience of dependency (in the past five years) who described the importance of feeling a sense of productivity and self-fulfilment, either through education or employment. Whether it figured directly in their conceptualisations of controlled problem-free heroin use or not, having responsibilities and

obligations was an important factor that helped non-dependent users maintain control over their use.

Life commitments and responsibilities also performed an important function for controlled dependent users. At a basic level, it provided a focus in life that was not drug related, which in many ways allowed heroin to become an integrated aspect of their everyday life. Take Dominic, for example. He had been using heroin in a controlled way for around 16 years, and used roughly half a gram a day. At the time of interview, he was employed as a painter and decorator. He also discussed playing music, buying and selling guitars, and renovating a house he and his partner (also a controlled dependent user) had recently inherited. Dominic's use of heroin did not have a debilitating effect on his ability to lead a full and busy life.

The degree to which heroin was an integrated part of their life also affected controlled dependent users' perceptions of their use. Most did not perceive themselves to be 'addicted' in the traditional sense; in other words they did not view heroin use as a debilitating affliction or consider themselves to be a 'slave' to the drug. As Edward and Rebecca explained:

It's just something I've lived with for many, many years now, and I carry on with my life with heroin in the background as it were.

(Edward, aged 59, a controlled dependent user for 30 years)

I want to make sure I can take pride in my appearance and what I do. I need to be occupied. I can imagine nothing worse than living on the

streets with nothing to do apart from make money to do drugs. I think it would be so depressing that I'd rather die than do that. So I keep myself going, and to actually have a quality of life that I'm happy, fulfil my dreams and ambitions ... so the reason I control is so that I can think of myself as Rebecca rather than a drug addict. I'd rather a drug addiction was a small part of me rather than something that defines me.

(Rebecca, aged 28, a controlled dependent user for ten years)

Being able to carry on life 'with heroin in the background' depended on having the money to be able to fund use which, in most cases, meant being employed. Other factors, such as having a partner, family, other interests and non-heroin-using friends, were also important. Life structure and commitments were influential in enabling dependent users to control their use of heroin. And the further heroin was pushed into the background, or became an increasingly integrated part of their lifestyle, the less it was perceived as an issue of any real importance. It simply became a small part of a much bigger life.

Attitudes and individual characteristics

Other researchers have highlighted the potential importance of psychological factors when attempting to understand the phenomenon of controlled heroin use (Shewan and Dalgarno, 2005). Although we did not ask interviewees about their individual attitudes or personality traits, some data were collected on these issues within discussions about control.

Data that did arise about individual attitudes involved interviewees talking about a healthy awareness, appreciation or fear of

heroin's 'addictive' qualities, as well as approaching their use with a great deal of respect for the drug. As Anthony explained:

... just treating it with a bit of respect and kind of ... yeah treat the whole process with a lot of respect and don't ... and especially the drug itself ... don't get too far into it. See what it has to offer and then ... and then leave it, you know.

(Anthony, aged 33, a non-dependent user for eight years, with no previous dependence)

Others mentioned that carefully researching the drug prior to trying it, associating heroin dependency with problematic lifestyles and having a positive self-image were factors that contributed to them controlling their heroin use.

Many interviewees talked about aspects of their personalities that they perceived had an effect on their ability to use heroin in a non-dependent and controlled dependent way. The factor mentioned most often was a desire to be in control and retain control of their life. Respondents also described themselves as cautious individuals, either generally or as a result of previous experience of dependence. Some claimed to have 'non-addictive' personalities. Others talked about being strong-willed, determined and self-motivated individuals. Undoubtedly some personalities are likely to be better suited to controlling drug use. However, it was beyond the scope of this study to examine this in a systematic way, for example through personality testing.

Access to heroin

A common theme amongst occasional and frequent non-dependent users was maintaining a distance between themselves and those who sold heroin. Some respondents were keen to avoid

having direct access to heroin and depended on friends or partners to buy the drug. Fred, for example, explained how he relied on his partner to purchase heroin and how this was used as a way of regulating his use:

I don't want a collection of smack dealers' numbers on my phone ... it is easy to see circumstances where you did use more often and if there wasn't that, hold on a minute I need to think, I need to talk to somebody before I score. If the decision to score becomes a single decision rather than a joint decision, then you have less in the way of checks and balances on that.

(Fred, aged 30, a non-dependent user for two years, with no previous dependence)

A number of respondents were supplied with heroin through friends. They did this to remain anonymous and keep their use hidden. Anonymity was desired because some wanted no involvement with those immersed in the drug world or heroin subculture, whereas others were concerned about their jobs, the stigma associated with being known as a heroin user and the prospect of arrest by the police.

Other respondents bought the drug themselves. However, they placed certain hurdles in the purchasing process to make it difficult. As Cameron explained:

I make it as hard as possible ... I mean I have to make a couple of phone calls and then drive for an hour, so it puts it out of my range ... I don't want to know people in that scene on my front doorstep because that would make it all the harder for me ... so I try and keep it as far away as possible.

(Cameron, aged 32, a non-dependent user for six years, previously dependent)

Accessing heroin worked in the inverse way for controlled dependent users. Controlled dependent users required a dependable supplier who was easy to access, as without heroin they would begin to feel ill. Most bought larger amounts of heroin because it was cheaper, which meant they spent less time trying to 'score'. This made the focus on heroin a smaller part of their daily lives. It also reduced the risk of contact with the police. Rachael, for example, reported:

Buying in bulk makes it cheaper. I do £40 a day, if I buy it once a week it'll be cheaper, so it doesn't work out £40 a day, it'll only work out at about £25 a day ... also I don't really like having to run around every day, putting myself on offer to the police or whatever, I'd rather just go buy it.

(Rachael, aged 35, a controlled dependent user for 12 years)

What people expected from the drug

From early on in the interview process it was clear that interviewees rarely talked about getting 'wrecked', 'caning it', feeling 'off their head' or striving for a state of oblivion. In fact, only a small number of respondents reported seeking and enjoying the more intense effects that heroin can generate. Most described using heroin in a relatively sedate way and seeking the subtler effects. Emma's description reflects this desire to use heroin in a managed and relaxed way:

... we do a little bit you know, you know it's basically to relax and chill out ... what I mean is we spread it out and instead of, some people will do a whole lot at once just so they can get blitzed out and there's nothing left. What the aim is is just to chill out and relax so we do a little bit and it

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makes you feel nice, fine, enjoy a bit more. So we do it like that, so we just retain that sort of level, relax a bit more.

(Emma, aged 47, a non-dependent user for 13 years, previously dependent)

Previous experience of heroin use

Our experience of the world, at least in part, helps to shape our behaviour patterns and belief systems. This was evident amongst our interviewees who often talked about how their direct or indirect experience of heroin helped to mould their individual reasons and mechanisms for controlling heroin use. Many described how their observations of other people's behaviour ultimately had an influence on their own. Joe described how his early and later observations of heroin users created a general wariness about the drug:

I knew a couple of people who had died and stuff ... I was always a little bit wary, I suppose ... I saw Phil [a friend Joe used with occasionally a number of years ago] in decline, a real huge decline. He really got back into it, kind of disappeared off the scene and that's something that really stuck with me. I saw him a year and a half later and he was a right mess.

(Joe, aged 31, a non-dependent user for seven years, with no previous dependence)

As well as increasing levels of caution about the pitfalls associated with heroin use, individual observations also had an influence over respondents' patterns of behaviour. Gillian, for example, described how her experience of watching people inject had led her to associate it with uncontrolled use:

My observations show me that people that inject, jack up, as they call it, they have no control and I personally find that degrading.

(Gillian, aged 60, a controlled dependent user for 30 years)

Interviewees also reported learning about control through trial and error and by making mistakes. Fear of becoming dependent again was one experience that contributed to the maintenance of control for some users, as Tracey explained:

I don't ever want to return to that lifestyle again. That's something that, yeah, it is something that I am aware of, definitely. It's almost like a bit of a lesson learned, you know what I mean, I had my fingers burnt a little bit and you take away something from that and it changes you as a person as well.

(Tracey, aged 32, a non-dependent user for two years, previously dependent)

Respondents also described experimenting with various patterns of use before finding one that best suited their situation. The following two quotes illustrate examples of this process for a non-dependent and controlled dependent user:

Although from experience using it once every seven days does, you know, you do get a little bit of a hangover the next day or a comedown, whereas if you use it once a month you don't get that. You just get a little bit tired as you've been up all night.

(Cameron, aged 32, a non-dependent user for six years, previously dependent)

It's taken me a little while to fine tune it to that point where that's my system because obviously

I have made mistakes so I have spent all my money and gone, fuck, I can't afford to pay my electricity and had to go and borrow some money off someone so I can live this week.

(Rebecca, aged 28, a controlled dependent user for ten years)

External pressures

Some respondents believed that they controlled their heroin use because they personally chose to. Others mentioned the existence of various external pressures. External pressures could include family, friends and wider societal pressures linked to the stigma associated with heroin use. Cameron and Richard both provided examples:

I think it would be highly embarrassing for me and highly hurtful for my family and hurtful to me if I was to get addicted again, you know it would tear my family apart and it would tear my girlfriend apart. It would upset all my friends that have stuck with me all the way through it, you know, so there are those things.

(Cameron, aged 32, a non-dependent user for six years, previously dependent)

I wouldn't call it a pressure; I'm more worried about the stigma what goes with it. People say smackhead. I'd hate to be called that. I know I use it, but I'd hate for somebody to say he's a smackhead. I wouldn't enjoy that at all, that would absolutely slaughter me.

(Richard, aged 38, a non-dependent user for 11 years, with no previous dependence)

One Asian respondent talked about cultural boundaries and the stigma associated with heroin amongst his community:

... you know there's such a stigma attached with that type of drug, the work I'm involved in and the Asian community ... I wouldn't like people in the community finding out ... the Asian community is quite close knit and word does get about ... they [respondent's parents] wouldn't be isolated from them, but they would feel personal shame themselves.

(Damien, aged 29, a non-dependent user for seven years, with no previous dependence)

Overall it is difficult to be precise about the nature and extent of the influence of external pressures, suffice to say they existed and, for some people, were clearly a factor that helped control drug use (how the perceptions of others influenced control is discussed in Chapter 5).

Controlled heroin use: two case study examples

The following two case studies show how the control mechanisms described above were used. As can be seen, several different strategies are combined at any one time.

Case study 7 Anthony – an occasional user

Anthony was 33 and worked as a musician. He first tried heroin aged 25, and has been using sporadically ever since. Anthony had never been dependent on the drug.

Anthony had used heroin three times during the past 12 months. There were a number of factors that influenced the way

(Continued overleaf)

Occasional and controlled heroin use

Anthony controlled his use. These included:

- *Following his 'using rules':*
 - only ever buying £20 worth of heroin (this was purchased from an open street market, so was probably considerably less than a normal £20 deal)
 - not injecting
 - using the heroin over one evening, and never going out to buy more the following day
 - not using heroin as an escape.
- *Using environment.* Using heroin was something that Anthony did with a particular friend who used in a similar way. Both had been friends for years and had a history of taking drugs together. Anthony described him as someone he 'felt comfortable doing drugs with'.
- *Life structure.* Anthony was married and had a successful music career. He had many responsibilities and commitments in life. However, he reported feeling no pressure from these obligations to maintain control of his use. He stated that using heroin was his responsibility, although he commented that 'it would be disastrous if it got beyond a respectable managed state'.
- *Attitudes and personality.* Having witnessed people become problematic users, Anthony reported being very wary about heroin because of its

addictive nature. He stated that he was not so much cautious or fearful, but very respectful towards the drug. Anthony stated he was not the type of person who needed to have more of a good thing.

- *Access to heroin.* Anthony always travelled to Soho to buy heroin. That way he did not become known by local dealers or those immersed in the local heroin subculture.
- *Desired effect from heroin.* He did not seek the 'big hit', but rather used heroin a bit at a time to enjoy the subtler effect – the warmth and relaxation.
- *Previous experience.* Anthony described how seeing a number of people come 'unstuck' on heroin when he was younger helped to shape his initial wariness about the drug.

Because of the way Anthony used heroin and the type of person he was, he felt that there was 'no danger' of losing control of his use.

The second case study (Gillian) is a long-term controlled dependent user who consumed a relatively small daily amount. At the time of interview, Gillian had been using heroin for over 30 years. Her use had fluctuated throughout this period, but had always been relatively problem-free.

Case study 8 Gillian – a controlled dependent user

Gillian was 60 years old and had retired. She had worked for the majority of her life in a professionally demanding job. She had two adult daughters.

Over the past few years Gillian had used £10 worth of heroin daily, which she tended to use on her own. Throughout the 30 years Gillian had been using heroin she had always worked (and had a successful career), she brought up two children and, after she retired, she cared for her terminally ill mother. Gillian funded her use via private and state pensions. Use, for Gillian, was no longer about getting ‘a buzz’, it was about maintaining herself and ensuring that she felt well.

There were a number of factors that enabled Gillian to control her use. These were:

- *Following her ‘using rules’:*
 - she only used £10 worth of heroin per day
 - she only snorted one line a day (which tended to be in the afternoon)
 - she would not inject
 - she ensured an eighth of an ounce (three and a half grams) lasted a month
 - she only used when she physically felt the need to do so (Gillian had always used in this way).
- *Life structure.* She reported always having been able to focus or stop using

when necessary. She cited the following examples: work, her daughter’s wedding, being pregnant, caring for her mother. At the time of interview, Gillian reported not using heroin in the morning because she did not need to and because she had things to do: for example, walk her dogs or work on developing her internet business – she was building the business website herself. Being a parent and a grandparent she had many family responsibilities. Using heroin was a very small but integrated part of a very busy life.

- *Attitude and personality.* When asked how she controlled her use, Gillian stated that she had thought long and hard about this over the years, and put it down to being strong-willed; she stated that she would not be beaten in life. She provided an example that involved her daughter’s wedding. Gillian organised the whole of this wedding. During this period she reduced the amount she was using each day to the absolute minimum, so that she could attend to the organisation. Whilst caring for her terminally ill mother (for two years) she did the same, although she periodically used cocaine. She described herself as someone who had to be in control, which was why she did not like alcohol. She also described herself as very disciplined. For example, she would buy an eighth of an ounce of heroin

(Continued overleaf)

every three or four weeks, but still only use one £10 line per day, despite having access to much more.

- *Experience.* Having known a number of injectors, she associated this with uncontrolled use. According to Gillian control is about self-respect too. She reported seeing the worst side of heroin and crack use and felt that she had set boundaries around her use which were based on not degrading herself or losing control or self-respect.
- *Drug expectations.* Gillian reported that she never wanted to feel 'off her head' and always wanted to be in control of her drug use.

Testing control mechanisms

Maintaining controlled heroin use will, for the large part, depend on the control mechanisms an individual employs, life structures and indirect influences. A good indicator of non-problematic and non-destructive patterns of heroin use, or a successful set of control mechanisms, is the length of time someone has been using in a non-dependent or controlled dependent way. As we explained in Chapter 3, the controlled dependent users in our sample reported stable patterns of use: four had been using heroin in a similar way for the past four years and six had been taking heroin with few problems for at least ten years (two reported using heroin non-problematically for 30 years). This group appeared to have a successful blend of different methods of control that enabled them to regulate their use.

It is tempting to speculate about the robustness of the control that our respondents exercised over their heroin use. What would happen if they were confronted with a crisis – such as a death in the family, a bout of depression, job loss or a relationship breakdown? Obviously it is difficult to predict how individual using patterns might change in future. However, what we can say is that most controlled dependent users in our sample described situations where they consciously adapted their pattern of use for specific purposes, and these situations included crises of various sorts. For example, Gillian (see case study 8) described purposefully cutting back her use whilst arranging her daughter's wedding, when caring for terminally ill parents and during busy periods at work, and, on two occasions, stopping whilst pregnant. Others described how they would adapt their use to the amount of money they could afford, or supplement or substitute heroin with a prescribed or illegally obtained alternative. Only one controlled dependent interviewee mentioned that she associated taking increased amounts of heroin with periods of depression, although she perceived this to be a form of self-medication as opposed to a problem of any sort. Far from being a 'slave' to the drug, it was clear that this group often made rational and deliberate choices about their heroin use based on circumstances they encountered in life.

As we have described, rules were commonly employed by non-dependent users to set boundaries around what was deemed acceptable use. How did respondents react when they broke one of their rules? They reported numerous examples of situations whereby they stepped outside their designated

boundaries, realised they had taken a step too far, and then pulled back. Fred, for instance, used heroin roughly twice a month and had a rule about not using for more than two nights consecutively. Below he described what happened when he broke that rule:

Certainly we've done that before [taken heroin for more than two evenings], we'd been on a major party session between Christmas and New Year ... and you discover, you look round and say this is the third night we've been doing this, stop now no more till next month ... I've done that once or twice, I've seen us turn round and say we're off this for a month, we're off this until the next pay cheque whatever.

(Fred, aged 30, a non-dependent user for two years, with no previous dependence)

Another example was provided by Claire who generally preferred to use heroin once a month:

I try and have a big gap. We've just had friend over from Kenya ... he's been over for a month, so we've used every single weekend while he's been over, and my husband and I both said I think we need to have a break now for a month, and we won't have anything for a month.

(Claire, aged 54, a non-dependent user for 19 years, previously dependent)

The two examples above show how using rules helped two users maintain control of their use. However, the example below shows how one respondent appeared to have reached a point where certain life problems were leading him to continue breaking some of his using rules. Richard felt that, for him, being dependent on heroin would represent problematic use. One of Richard's rules involved buying only a small amount (£10 worth) of heroin, so that he would

use it all in one evening and have none left over to use the following day. Richard was keen not to use on two consecutive days as he felt this was habit forming. He had been using heroin for 11 years without experiencing a period of dependency, although lately his use had increased from once a month, to once a week, to a few times a week. He attributed this increase to a 'pretty shitty period' of his life that included the breakdown of his marriage and a demanding custody battle for access to his children. Richard explained how his use had reached an important crossroad:

I might do two days in a row, two or three days. And to be honest with you just lately I've been starting to feel niggles, backache and things like that, when I haven't been using, so I know I'm getting to the point now if I don't break this routine that I'm getting into, I'm going to end up needing to do a week off work for the withdrawals.

(Richard, aged 38, a non-dependent user for 11 years, with no previous dependence)

A small number of respondents demonstrated an awareness of the precariousness of their relationship with heroin. As Nigel explained:

If a load of bad things happened to me and I was in a situation where I had a load of money or access to drugs, if I got thrown out of Uni, my girlfriend dumped me and I couldn't get a job, I was back in Brixton with the wrong people then it would probably be a problem ... if a load of stuff happened to me then I'd be like, fuck it, buy drugs. That's always been my coping mechanism for bad things.

(Nigel, aged 25, a non-dependent/controlled dependent user for five years, previously dependent)

However, most non-dependent users appeared fairly confident in their ability to maintain control of their heroin use, particularly those who had been using in this way for a while and who had no previous experience of dependency, and those with settled, structured and controlled lives.

Chapter summary

This chapter has described the factors – or control mechanisms – that enabled our sample of non-dependent and controlled dependent users to regulate their heroin use. We found variation in the way people controlled their heroin use. Deployment of control mechanisms depended largely on the individual, the way they used heroin and their personal circumstances. We also found that the control mechanisms people employ were not fixed: they depended on many factors that often changed over time.

A key feature of the stereotypical image of a heroin user involves the abdication of responsibility for drug use and other behaviour. Yet having life structure, commitments and obligations was an important aspect of control. Many respondents articulated the benefits of feeling productive, fulfilled and having a stake in society. Our sample of controlled dependent

users – or those who used in a ‘stable state’ – was the group who most starkly contradicted this popular assumption. They talked about the importance of being employed, having a partner, focus and direction, support structures and non-heroin-using interests and friends. This had two important functions. First, it provided the motivation to maintain controlled using patterns. And second, it lessened an individual’s focus on heroin, which pushed the activity into the background and served to distance them from the stereotype described above – it helped them reject the ‘junkie’ identity.

The important point is that dependency did not represent a debilitating affliction to this group; rather they continued to make rational and autonomous decisions about how best to manage and regulate their daily heroin use. In fact, the existence of life structures and commitments was partially responsible for creating the circumstances in which this was possible. For example, when respondents discussed their experience of losing control or their perception of problematic use, most associated this with losing control of situations in their lives, not necessarily the drug itself. By examining users’ perceptions of their heroin use, the next chapter deals with some of these issues in greater detail.

5 Perceptions of heroin use

This chapter describes our users' views of controlled and uncontrolled drug use. We explore their perceptions of how others may see their heroin use and discuss their future intentions regarding heroin, including the need for helping services.

Defining controlled use

In-depth interviewees were asked what aspects of their heroin use led them to define their use as controlled. They interpreted controlled heroin use in a variety of ways. However, responses focused on the unobtrusiveness of use in other aspects of their lives, on frequency of use and on the informal control mechanisms they employed to regulate their heroin use. They often compared their current patterns of use with previous episodes of uncontrolled use.

Important in many interviewees' explanations of control was the way in which heroin use had become a normal and routine part of their life. Some indicated that heroin was simply one drug in their repertoire of recreational drugs. Many drew analogies with alcohol use, for example:

It's just something I do now and then with about the same frequency as going for a night out on the beer.

(Jason, aged 32, a non-dependent user for nine years, with no previous dependence)

Most explanations of controlled use also mentioned the absence of disruption to normal daily activity: for example, that use of heroin did not have an impact on relationships with family and friends, work, housing or financial situations. This is illustrated in the following quotes:

It's only something I do in my spare time.

(Joe, aged 31, a non-dependent user for seven years, with no previous dependence)

... say I'm working on a script, [and think] 'Oh I must stop and do that [use heroin] instead' or I have to rush home because I want to [use heroin]. I never do that.

(Ted, aged 46, a non-dependent user for 29 years, with no previous dependence)

... it's incorporated into my life ... it doesn't impinge on anything, I'm able to work, I'm able to live my life as I want to, so it isn't a problem.

(Emma, aged 47, a non-dependent user for 13 years, previously dependent)

It hasn't stopped me caring for my mother and father, bringing up my children, looking after my husband ...

(Gillian, aged 60, a controlled dependent user for 30 years)

Another important aspect of explanations of control was the concept of 'no harm done'. The absence of negative consequences for the individual heroin user, their family, friends and society as a whole was an important part of defining control. Funding heroin use legally rather than through crime was often seen as a definitive marker of controlled use.

I'm not getting ill from it, it's not doing anybody else any harm, it's making me feel relaxed and I'm getting what I want out of it.

(Ian, aged 33, a non-dependent user of 11 years, with no previous dependence)

... no-one else gets affected, so you're not causing no-one else harm, no-one gets robbed.

(Fiona, aged 34, a non-dependent user for four years, previously dependent)

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I don't feel it's harmed my health, I don't think it's detrimental to my relationship with my girlfriend, or with my family, it doesn't affect my work in any negative way ... I can't really perceive any way it might be harmful to me at the moment.

(Craig, aged 28, a non-dependent user for nine years, previously dependent)

Many respondents evaluated the risks and harms associated with other legal and illegal drugs. Again the comparison with alcohol was made: some interviewees contrasted the impact of their use of heroin as negligible compared to that associated with alcohol consumption.

... some people may go out and drink eight pints in a night. To me, I wouldn't ever, I wouldn't do that, it's not something I would enjoy doing. But a bag of heroin ...

(Tracey, aged 32, a non-dependent user for two years, previously dependent)

The one that worries me the most ... has been the drink.

(Ted, aged 46, a non-dependent user for 29 years, with no previous dependence)

Others associated the potential for uncontrolled patterns of use with other illegal drugs, particularly crack cocaine:

The only drug I ever potentially could have had a problem with was crack ... it's a very short, sharp, major high, you're up, it lasts about 20 seconds, you've got a nice buzz for a minute and then it's straight back down again and you think oh God, quick, that was really good, I don't want to feel like this, let's have some more, and you can just go round and round like that for hours.

(Kirsty, aged 32, a non-dependent user for 13 years, with no previous dependence)

Another commonly mentioned dimension of control was the frequency with which heroin was used. As would be expected, this aspect of control was primarily described by those who were non-dependent users. Controlled dependent users, who use much more often than others in this sample, were less likely to mention regularity of use as important to their definition of controlled use. However, a range of patterns of heroin use was mentioned in users' explanations of control, as can be seen from the quotes below:

[I don't use heroin daily] ... so I haven't got a habit. If it was daily, even if I could afford it, it would be a problem.

(Douglas, aged 51, a non-dependent user for four years, previously dependent)

The controlled use is not having to do it, being able to go without, being able to go, I mean just as an example, I would say if you can go seven days without using it then you haven't got a habit ... yeah you choosing when you're going to do it, not it choosing when you're going to do it.

(Cameron, aged 32, a non-dependent user for six years, previously dependent)

For others the absence of the desire to use was important in their definition of control. As Fred explained:

... you can buy the drug on Monday and say let it lie there until Saturday, when I want to use. If you can do that then I don't think drug use is problematic.

(Fred, aged 30, a non-dependent user for two years, with no previous dependence)

If all of a sudden I haven't got any money I can go without.

(Jane, aged 23, a non-dependent user of one year, previously dependent)

Understanding controlled use of heroin was primarily related to previous experiences of uncontrolled use for some:

Trial and error ... after using and knowing what makes me get dependent and how much.

(Mary, aged 42, a non-dependent user for eight years, previously dependent)

The absence of specific problems often related to 'problematic' drug use was also mentioned, in particular not having any contact with the criminal justice system. However, many mentioned their concern about being caught in possession of heroin and the impact that this could have on their lives. Many felt that the risk of arrest was a threat that could change their entire lives instantaneously, and could totally undermine the control they exercised on their life and drug use.

When does it become a problem?

All respondents in the online sample reported that 'overall' they considered their heroin use to be non-problematic ($n = 123$). This did not necessarily mean that they considered their use of heroin to be entirely problem-free, however. Some stated that their heroin use never caused them any problems (29 per cent), some indicated that it rarely caused them problems (37 per cent), others stated it sometimes caused them problems (22 per cent) and some were unsure whether it caused them problems or not (12 per cent).

In-depth interviewees held a number of beliefs about what constituted problem use. For most, heroin use having an impact on their everyday lives was the biggest concern:

Being invited to go away with friends and not being able to do it because you need drugs or you need to inject.

(Mary, aged 42, a non-dependent user for eight years, previously dependent)

... it's putting it before things that mean something to you.

(Fiona, aged 34, a non-dependent user for four years, previously dependent)

... if you wake up in the morning and it's the first thing you think about.

(Ken, aged 19, a non-dependent user for two years, previously dependent)

Also often mentioned was increasing the frequency of use and drug-using activities becoming more time-consuming. For some, problem use was defined more by the perception of a change in their relationship to the drug or the environment in which it was used, as the following quotes illustrate:

... if the drug starts using me rather than me using it.

(Rachael, aged 35, a controlled dependent user for 12 years)

If I found myself sitting on my own with a bag of smack about to smoke it by myself ...

(Fred, aged 30, a non-dependent user of two years, with no previous dependence)

Others finding out about their heroin use was seen by many as a factor influencing their perception of problem use. Interviewees also expressed particular concern about the impact on close relatives:

... for [my mother] to find ... it would be catastrophic in terms of her sort of physical health

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and mental state of health. She's 88 years old and that kind of shock would not be good for her, so that would make it a problem.

(Edward, aged 59, a controlled dependent user for 30 years)

At a practical level the inability to sustain the financial burden of their illegal drug use would be an obvious sign of problematic use:

... if I couldn't pay my bills, if I couldn't go out and buy the materials for a job. So if I came to the point where I woke up one morning and thought, 'Shit, I haven't got enough to go and buy the timber I need for today', then it's a problem.

(Richard, aged 38, a non-dependent user for 11 years with no previous dependence)

... when you have to make a choice. You don't get the shopping, you don't pay the rent ...

(Francesca, aged 45, a non-dependent user for two years, previously dependent)

One interviewee mentioned he would view his heroin use as a problem when it had ceased to be pleasurable.

When it stops being something that I'm doing to be enjoyable.

(Nigel, aged 25, a non-dependent/controlled dependent user for five years)

Secrecy about heroin use

Those who participated in the online survey felt that the general perception of heroin use across society was very negative. Views of heroin use in the media, among work colleagues and non-drug-using friends were seen in 'black and white' terms – that users must be addicted and must therefore commit crime. Close family and

friends and drug-using friends were believed to have less negative views – but with many reservations. The impact of the judgement of others was evenly balanced between those who had little concern about others' views (42 per cent) and those who had some concern (42 per cent). Many respondents said that, apart from families and partners who already knew about their use of heroin, they would be uncomfortable with anyone knowing.

Understandably this was particularly the case for those with work colleagues. The majority maintained that they would not introduce anyone else to heroin and would feel uncomfortable using heroin in front of non-users.

All except one of our interview sample did not commit crime and did not perceive themselves to be 'addicts' in the traditional sense. Not fitting society's stereotypical image of a heroin user, most were keen to avoid being labelled or thought of in this way. This led many to hide their use from those around them. In many ways this was about protecting an individual's self-image. As well as simply not wanting people to know about their heroin use because of the negative stigma associated with it, this process allowed respondents to maintain a 'non-addict' self-image. This also contributed to the way our sample controlled their heroin use.

A few respondents explicitly mentioned the importance of limiting the number of people who knew about their use of heroin as a control strategy. Some took pleasure in keeping their heroin use a secret or saw no benefit in telling others. As Mary noted:

It's my secret ... there is something in me which loves to hold this secret.

(Mary, aged 42, a non-dependent user for eight years, previously dependent)

I don't need to tell anyone. If it affected them and I was using it more often or that sort of thing but it doesn't ... it's my personal enjoyment and I don't need to share it with others.

(Philip, aged 32, a non-dependent user for two years, previously dependent)

For one interviewee, telling others about his use of heroin was a political statement, believing that he should be free to use whatever drug he chose to as long as it caused no harm, and he refused to keep his use private.

I'm what you could describe as an 'out' user.

(Joseph, aged 47, a non-dependent user for ten years, previously dependent)

Most interviewees had disclosed their use to a select few. Close family (parents and siblings) often had not been told, as well as work colleagues and employers. Often friends and family knew about other drug use (such as ecstasy and cannabis) but not heroin. Being selective was important for a number of reasons. Not letting family and friends know was generally related to the perceived level of distress the knowledge would cause. Not telling colleagues at work about heroin use related to realistic fears about job loss.

Partners and friends were most frequently mentioned as knowing about an interviewee's use of heroin. For many it was difficult to hide their use from their partner. Many friends, although not heroin users themselves, had used other drugs in the past and could be trusted with the information. Some mentioned having

told specific individuals about using heroin for purely practical purposes.

My sister's the only one that knows, and the reason for that is she is my daughter's legal guardian if anything happens to me. I'm very careful but you never know.

(Emma, aged 47, a non-dependent user for 13 years, previously dependent)

How others see it

We asked our interviewees about perceptions of how others see heroin use. Views varied according to whom they had told.

Those who know

Many interviewees mentioned that the views of their friends and family were often, after an initial period of shock, ones of begrudging acceptance. Many mentioned the phrase: 'As long as I'm well they don't mind'. A level of acceptance had been achieved by some of our interviewees as the following quotes demonstrate:

They have got used to it ... even injecting.

(Jake, aged 41, a non-dependent user for two years, previously dependent)

My best friend is cool about it ... but he would soon tell me if he thought I was developing a problem.

(Ken, aged 19, a non-dependent user for two years, previously dependent)

It doesn't cause a problem, we still get on fine, every couple of weeks we go to my sister's for a barbecue, we'll all get on fine. They don't shun me or give me a hard time.

(Dominic, aged 46, a non-dependent user for five years, previously dependent)

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Acceptance was important for some because it also meant they received some support at difficult times:

I told this friend that I got into a bit of a scrape while buying drugs in Brixton. He didn't know I used. He was very supportive.

(Colin, aged 34, a non-dependent user for two years, previously dependent)

As case study 8 outlines, making others aware of their use of heroin had major consequences for some.

Case study 8 Gillian – a controlled dependent user

Gillian's heroin use has been described in Chapter 4. Gillian had been a controlled dependent user of heroin for 30 years. She had two adult daughters and was married, and although she shared the same house as her husband, they lived relatively separate lives.

Until six months before the interview, Gillian had hidden her use from her family and close friends. She then decided to tell her husband and daughters that she was a dependent heroin user, or rather she allowed them to find out, by leaving some lying around. After all this time, Gillian was unsure exactly why finally she wanted to tell them, although she felt it had something to do with her heroin use being a secret for so long. After telling them, she reported that her husband and daughters had treated her in a completely different way. She stated:

They think I'm going to die any minute. I'm living on a different planet.

Gillian described how the situation had caused huge arguments with her daughters. Gillian felt her family applied many of the stereotypes about heroin users to her. For example, her husband became very controlling over their money. Despite explaining that she had used heroin for 30 years in a controlled way, Gillian felt that her husband was concerned she would attempt to spend all their money on the drug. This resulted in him restricting her access to their joint accounts. She was unable to persuade them that her heroin use actually caused her very few problems.

Those who do not know

One of the main reasons why non-problematic heroin users do not divulge their use of heroin is fear of how others will react. Most of our interviewees believed that people would be shocked and appalled because they drew their information about heroin from narrow media portrayals of evil heroin users.

You know the general conception of someone who takes heroin, it's not measured, it's pretty extreme.

(Charles, aged 24, a non-dependent user for six months, with no previous dependence)

Some mentioned that they believed the reaction to such information would vary depending upon who was offering their views:

... friends would be ok ... I'm not sure about work colleagues.

(Emma, aged 47, a non-dependent user for 13 years, previously dependent)

... my parents and family would just lose the plot.

(Joe, aged 31, a non-dependent user for seven years, with no previous dependence)

A general concern of the interviewees was that people would lose their trust in them and break off friendships or relationships.

... my family wouldn't want anything to do with me. That's what scares me the most, being ostracised, I haven't done them any wrong, but it's what they learn from the media.

(Clive, aged 44, a non-dependent user for three years, previously dependent)

My close friends and family know. Others? They don't know for a reason. Because I work with them or I know they would have a problem with it, and I don't want to be judged by them.

(Rebecca, aged 28, a controlled dependent user for ten years)

Future use

We asked questions about using heroin in the future. Only two interviewees reported that they did not think they would use heroin in the future. All the others expressed a degree of comfort with their heroin use and did not see a point in the immediate future when they would want to stop.

I have no intention of stopping. It's a long-term commitment to prove I'm right to start. I do enjoy it and I don't see why I should do without it.

(Jake, aged 41, a non-dependent user of two years, previously dependent)

It's still quite positive for me ... I still get ... a nice buzz out of it, still pretty similar to the first time I used.

(Cameron, aged 32, a non-dependent user for six years, previously dependent)

Many had the attitude that 'if it ain't broke, don't fix it', that heroin use is currently causing them no difficulties so there is no reason to stop. Some mentioned that stopping use could actually cause problems, for example the use of other drugs like alcohol, which they believed would be more damaging.

Some interviewees mentioned circumstances under which they would consider stopping their use of heroin. This usually related to the possibility that heroin use stopped being a pleasurable experience, or that the problems associated with maintaining a supply of the drug became too intense. For women, becoming pregnant was a point at which they believed they would stop using. But one female interviewee felt that she would consider returning to heroin use after the birth:

... this will sound terrible, just because I will have a baby why should my recreational drug use stop? That's really selfish. I don't know maybe my whole perspective will change when I have a baby.

(Tracey, aged 32, a non-dependent user for two years, previously dependent)

Do they need help?

We asked our interview sample whether they thought they needed any help associated with their heroin use. Most believed that they required no help. For example:

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Even when I was addicted to heroin, there wasn't really anything they [services] could do because my life was fine, I had all the bills paid, I was in work, I had a nice house, food in the fridge, no worries ... perfect social life, girlfriend, good family life. What could they do for me?

(Nigel, aged 25, a non-dependent/controlled user for five years)

Although few interviewees reported wanting any direct help, some suggested that the availability of credible information about drugs and the associated risks would be helpful – more for others than themselves. There was a strong view that the current information available about heroin was inaccurate and that it was important that realistic information was offered. Jason outlined this point:

... the messages are all wrong. 'Drugs are bad don't do them' rather than 'drugs are bad don't do them but for God's sake if you do, do them like this and be aware if you do do them this might happen or that might happen'.

(Jason, aged 32, a non-dependent user for nine years, with no previous dependence)

Several interviewees felt that they might benefit from some counselling not only about their drug use but also about other aspects of their lives which they related to the use of drugs. They were concerned, however, that such counselling should be provided on an informal basis:

There is probably scope for people to come around and sit and have an informal chat, without people having to engage too heavily in services.

(Ian, aged 33, a non-dependent user for 11 years, with no previous dependence)

This quote illustrates the real concern expressed about getting too closely involved with drugs services. Many interviewees voiced a deep mistrust of services, believing they had nothing to offer them:

The treatment system produces people who are incapable of doing anything. It prevents you from working, you can't drive, get a mortgage.

(Shaun, aged 35, a non-dependent user for one year, previously dependent)

They see you as a particular type of person whether you are or not, so if you are working and trying to minimise problems they can't really cope with that, they don't really understand that.

(Emma, aged 53, a controlled dependent user for 17 years)

There is help to a certain extent out there but you've got to know how to access it and a lot of these people just don't have the skills to be able to access it.

(Gillian, aged 60, a controlled dependent user for 30 years)

I think drug workers are very badly trained, have very little knowledge about drugs and very little understanding. They also assume that you are an addict or you are not.

(Claire, aged 54, a non-dependent user for 19 years, previously dependent)

Generally interviewees wanted more honesty to be shown by services and a genuine approach to offering help. Some thought this would be best achieved by providing accurate and practical advice:

There could be more useful information. For example ... they could say you know if you have a slight problem or you feel like you are getting

withdrawal [symptoms] get some codeine, ask your dealer about methadone, ask your dealer for valium.

(Cameron, aged 32, a non-dependent user for six years, previously dependent)

Chapter summary

The consensus amongst our sample was that heroin use became a problem only once it began to intrude into their everyday lives: for example, once it began to affect their employment, health or relationships with others. Interviewees perceived heroin to be viewed negatively by non-users and society at large. Many felt that thinking about heroin was shaped by discussions and representations in the media, which often portrayed heroin users as evil,

untrustworthy, uncontrolled and morally corrupt individuals. This prompted most respondents to hide their use from those around them.

By hiding their use, this group were able to function in society without been thought of as heroin users; they were able to go about their daily lives without being labelled and stigmatised. Avoiding been labelled with the negative social stereotypes associated with heroin enabled users to protect their self-image. As well as simply not wanting people to know about their heroin use because of the negative stigma associated with it, this process allowed respondents to reject the 'addict' identity. Not thinking about themselves as an 'addict' or a slave to heroin undoubtedly contributed to their capacity to control their drug use.

6 Conclusions and discussion

This study has focused on a largely hidden population of non-dependent and controlled dependent heroin users who saw their use to be relatively problem-free. Our findings suggest that sustained heroin use does not inevitably lead to dependency, and that dependency will not always cause users significant problems – particularly involvement in crime and personal degeneration. We have demonstrated that, for some people, using heroin does not strip them of the ability to make conscious, rational and autonomous decisions about their drug use. The descriptions of heroin use presented here contradict the stereotypes that are to be found in the media’s treatment of the topic and political statements about it. They almost certainly conflict with popular beliefs about the drug.

Before considering the implications for policy, we shall summarise our key findings. It may be useful to preface this summary with a clear statement about what we are *not* saying, as the risks of sensationalist misrepresentation are high. This report has described how a small number of people managed to control their heroin use successfully. We are *not* suggesting that controlled drug use is a possibility for everyone. We are *not* denying that heroin can have a devastating impact on people’s lives, on the lives of their families and friends, and on the wider community. We are *not* denying that heroin use poses serious risks to users. Our key finding is that heroin affects people in different ways and that some people, in certain circumstances, can effectively manage their use so that it causes them few problems. If debate about drugs is to be rational, it is important that this fact is recognised, and that constructive lessons are drawn.

Key findings

Research on heroin use typically focuses on those in treatment or those passing through the criminal process. These are the most visible populations of heroin users. The users in our study differed from these groups in important ways. Their use was generally hidden from those around them, and they regarded it as largely problem-free. Most were in work or studying. They were more affluent than those in treatment, and had better accommodation. Most owned or rented their own homes. Their heroin-using careers were very varied. Interviewees reported patterns of:

- stable mid- to long-term non-dependent use without ever incurring a period of dependence
- mid- to long-term non-dependent use after experiencing a period of dependent/ problematic use
- stable mid- to long-term controlled dependent use
- transition (they had recently used dependently or problematically) and new using.

Our interviews revealed much about the process of control. Most respondents applied ‘using rules’ such as:

- not injecting heroin
- not buying heroin if they could not afford it
- not using heroin for more than two/ three days consecutively
- being in the right frame of mind before using heroin, i.e. not using it to escape

from problems in life but using for enjoyment

- buying a set amount and not buying any more once that had run out.

The concept of 'controlled use' was interpreted differently by non-dependent and controlled dependent users. The focus for non-dependent users was on regulating the frequency of use; controlled dependent users placed a greater emphasis on ensuring that their use did not intrude into their everyday activities. Both groups tended to draw on previous experience of uncontrolled use to define their current use.

Many respondents were discreet, and some were secretive, about their use. They were keen to avoid being 'labelled' as heroin users – a factor that helped them control their heroin use. Most users had no incentive to give up their heroin use, as they thought it caused them few problems. Many interviewees were also distrustful and disinclined to engage with treatment services.

How big a group?

This study has established, convincingly we hope, that there are subgroups of heroin users who are either non-dependent or dependent but stable and controlled in their use. The nature of our research means that we can hazard no guess about the representativeness of our sample, or the size of the population from which our sample was drawn. The conclusions that we have drawn are valid, we hope, regardless of whether the population of controlled users represents a very small minority of heroin users or a large minority. However, it strikes us as

self-evident that better estimates are needed of the number of non-problematic heroin users. The methods that are needed to do this are for epidemiologists to specify, and we do not propose to offer suggestions here.

Applying the learning about controlled heroin use

We have shown that, albeit through complex and multiple means, some users are able to control their heroin use. This finding has important implications for how individuals think about their drug use, for helping clients of drug services begin to manage their drug use, and for developing harm reduction material designed to help users manage and maintain control of their use.

Implications for treatment services

The concept of controlled drinking has become well established in the alcohol field. In the United Kingdom, a reduction in alcohol consumption or a switch from problem drinking to controlled or managed drinking is considered an appropriate treatment goal for some clients (Rosenberg *et al.*, 1992). In fact, current debate focuses less on whether controlled drinking is a possibility and more on the types of people best suited to such treatment goals (Cox *et al.*, 2004).

The learning about managed and controlled heroin use described here could be applied to groups for whom use is uncontrolled. In particular, this learning could be used to help drug treatment workers deal with clients who are attempting to stabilise and control their heroin use, rather than give it up. Some heroin users who enter Tier 2 (open access) or Tier 3 (closed access) treatment services are very reluctant to

give up heroin use altogether, and many are not willing to engage with substitute prescribing. A more realistic treatment goal for these clients, at least in the short term, might be managed/controlled heroin use. Currently there are no assessment tools, guidance or frameworks to help day-to-day practitioners respond to these client needs. In our view, such tools and guidance would be compatible with the National Treatment Agency's triage assessment system, in which drug workers assess individuals' needs according to priorities and then tackle them accordingly. The findings we have presented about controlled heroin use could be a useful starting point from which an assessment tool or guidance might be developed.

Clearly this approach poses dilemmas for drug workers about collusion with their clients' illicit drug use. However, if this problem is seen as surmountable, we see no reason why the concept of controlled drug use – already well established and readily applied in the alcohol field – could not be used as a legitimate treatment goal for clients of drug treatment services. In our view, the greater good is served better by a strategy that promises to contain and regulate clients' illicit use than by one which drives them away from drug services altogether.

Implications for harm reduction material

Policy should aim to dissuade people from trying heroin. However, it is inevitable that a proportion of individuals will try the drug. For some, that will be as far as it goes; others may progress to use heroin more frequently. This study shows that medium- and long-term non-dependent heroin use is a possibility for some people. We found that successful management of non-dependent use is reliant on a number of

things, one of those being clear boundaries that govern when and how use occurs. In order to prevent escalating levels of use and help new users maintain control of their heroin use these findings could be translated into a form of harm reduction leaflet. This could be done by explaining how using rules can create boundaries which help users control their use and by presenting real-life case studies.

An interesting idea to come out of our in-depth interviews involved the provision of advice about how to reduce or get off heroin on your own. This idea has considerable merit in view of our interviewees' mistrust of drug services and their own experiences of self-detoxification using illegally obtained heroin substitutes. For those wanting to move from controlled dependent use to non-dependent use or abstinence and for those who have stepped over their boundaries, information about how drugs such as codeine, valium and methadone should be safely used would be of much use.

There will be other ways advice or information could be offered to those users who want to remain invisible, but are concerned that their heroin use is beginning to cause them problems. One possibility is to develop innovative pre-treatment web-based services. Such services might include self-assessment tests that provide an indication about how controlled an individual's heroin use is. They could provide advice about the process of, and risks in, becoming dependent and how to maintain controlled patterns of use, as well as facilitating access to services for those who decide they wanted to take that step. Another option would be better advertised and resourced anonymous helpline services, such as the one offered by the drug charity Release.

A vulnerable group

Despite reporting stable patterns of use, many of the users interviewed for this study felt aspects of their drug-using lives were fragile. They had particular concerns about being arrested for the possession of heroin. The consequences of this could potentially have a destabilising impact on their relationships, lifestyle and employment (the main stabilising factors in most people's lives). A radical – but, in the current climate, politically unrealistic – approach to resolving this issue would be to reform legislation on personal possession, as has happened in some European countries. In Portugal, for example, possession and use of all illegal drugs have been decriminalised. Since Law 30/2000 came into force in July 2001, those caught in possession of any drug – including heroin – have the drug confiscated and are required to meet with a commission comprising a lawyer, doctor and social worker. In conjunction with the individual concerned, the commission evaluates any treatment, education or social needs on an individual basis and then makes the appropriate referral (EMCDDA, 2005).

Another – more realistic – option might be for the police to exercise wider discretion in the way they apply the existing legislation. Some police forces already issue cautions for the possession of heroin, and this practice could be extended. It is well established that street warnings can be given to those found in possession of cannabis. There is no legislative obstacle to following similar practice for those found in possession of heroin under well-specified circumstances.¹

Dependence: a social construct?

We have described a group of heroin users who fail to fit in with popular conceptions about the drug, for example that heroin use inevitably leads to dependent and destructive patterns of use. Below we reflect on the differences between the users in our samples and this popular assumption. In doing so, we suggest that dependence is – at least in part – socially constructed. That is, the expectation and belief that heroin is uncontrollable lead individuals to use the drug in this way. We raise the possibility that a clearer popular understanding about heroin use might ultimately bring about a reduction in problem drug use.

Reality, the popular view and users' self-image

The popular image of a heroin user is that of a powerless downtrodden 'junkie', injecting heroin at the bottom of a squalid back alley. Heroin use and heroin users carry connotations of dirtiness, contagion and criminality. We should remember that the stereotype of a heroin user is exactly that – a stereotype – from which the reality can differ. We have shown that some people can use heroin and look after themselves and their families, hold down a job, remain in relatively good health and have a full social life.

The issue of social stigma is a tricky one for policy. Aiming to change the way people think about heroin is a politically risky strategy, given the highly politicised nature of drug policy debate and sensational media reporting. One option is to maintain the status quo – continuing to feed 'addiction' stereotypes in the hope that they deter people from using heroin. Whilst this may well prevent some people from using

heroin, it certainly has failed to deter others, as the rise in problem drug use has continued.

The second – and arguably more honest, if politically challenging – option is to begin debating and presenting heroin use and heroin users in a more realistic light. Most people in our sample hid their heroin use and were fearful of the consequences of disclosure. Being labelled as a heroin user could have resulted in social isolation and exclusion from ‘normal’ activities such as working, social and family life.

Paradoxically the invisibility of this group is one factor that allows the stereotypes described above to take hold. However, presenting heroin in more balanced terms may help to safeguard controlled dependent users and reduce their vulnerability. Perhaps more importantly though, a better understanding about the nature of dependence could show those who are currently using problematically/dependently that there are alternative ways of using heroin that do not necessarily result in a severe breakdown of everyday life.

If heroin and heroin use were better understood by the general population and did not have the negative profile they do now, we may begin to see different patterns of use. By this we mean that if the possibility of controlled – and largely problem-free – use became a widely established one, we may begin to see fewer people abdicating responsibility for their heroin use, fewer people needlessly locked in destructive patterns of use, and increased levels of self-regulated heroin use. A better popular understanding about heroin use may also mean that those who encounter problems might seek help from friends and family far more quickly because they no longer run the risk of castigation and exclusion. Our argument is that

dependence and some of the problems associated with it are – at least in part – socially constructed. We believe that by changing the way people conceptualise heroin use, policy could begin to encourage people to take responsibility for regulating their use and seeking help if necessary.

It is important to be honest and open in presenting objective information when engaging in any sort of drug prevention work. The merest suspicion that information presented is incorrect or inaccurate and does not correspond to an individual’s experience of the drug is likely to undermine any further preventative efforts, as the message will be immediately discounted. To prevent people using heroin it is important to make accurate representations of all drugs, and to help people understand how heroin works it is important to make accurate representations of control, dependency and problem use. Prevention policy premised on false or inaccurate representations of heroin use – as with other drugs – will fail unless they accurately reflect people’s experiences of the drug.

A problem of exclusion?

Although our findings are based on a small sample, it was clear that an important part of maintaining and achieving stability of drug use was having something to lose. All our respondents had an investment in something. This has several implications.

The biggest is that heroin itself does not necessarily generate problems; rather problems and problem use are often caused by inequality of access to social goods such as healthcare, employment, education or housing. Limited access to such opportunities can breed feelings

of disaffection, alienation and exclusion that can have a strong influence over individuals' dignity, self-worth and sense of freedom. Although they are not the only factors, our findings suggest that social exclusion is often antecedent to patterns of problem use. Others have gone further and argued that problem drug users are a useful scapegoat by which attention can be deflected from the failings of socio-economic policies to benefit the full cross-section of society, and that social change, not individual users, ought to be the main policy focus (Friedman, 2002).

In terms of services for problematic heroin users, our findings provide further evidence of the need to focus on a range of life issues and not solely on drug use. Prevention of problematic patterns of use may be best achieved by focusing on access to opportunities in education, housing and employment. Improving life opportunities and providing people with a stake in society may have a strong stabilising influence on drug-using patterns.

A recent Audit Commission report also highlighted the lack of integrated support for drug users and concluded that life structure and self-sufficiency (particularly in terms of appropriate housing and employment) were important factors in reducing problem drug use (Audit Commission, 2004). Government policy has begun to address this issue in the form of the Drug Intervention Programme (DIP) pilot, a beginning-to-end programme that follows individuals from point of capture in the criminal justice system and – at least in theory – provides throughcare and aftercare related to housing, financial management, support with family

relationships, mental health, education and employment (HM Government, 2004). This pilot, if successful, may form a framework for a much needed holistic approach to dealing with problem heroin use.

Reducing problem drug use and helping problem drug users stabilise their lives are unquestionably important policy goals. In reality, however, current policies are reactive and solely address the symptoms of the problem – i.e. they address problem drug use once it has occurred. To begin to effectively tackle problem heroin use, it will be necessary to address what causes people to become problem drug users in the first place.

Final thoughts

Current debate about heroin policy rests on narrow stereotypes of the drug, how it is used and its impact. Current policy promotes these stereotypes, and the stereotypes reinforce the legitimacy of current policy. We believe that drugs policy has a greater chance of success the more that it is grounded in accurate assumptions about the nature of drug use. We also think that drug dependence is to some extent *socially constructed* – that public beliefs about drugs such as heroin determine how people actually experience them. It is possible – but not provable – that the way that public stereotypes of heroin use are deployed may help create the highly destructive role of 'junkie' that many heroin users occupy. In a world in which heroin is increasingly available, policy should do all that it can to undermine this stereotype.

Notes

Chapter 1

- 1 We prefer the term 'dependency' to that of addiction, precisely because it lacks the connotations of a mechanical, inexorable process.
- 2 Policy on cannabis is, of course, the exception, although the greater tolerance that led to reclassification may prove to have been a 'flash in the pan'. See Warburton *et al.* (2005).
- 3 Drugs research has typically focused on heroin users in treatment or involved in the criminal justice system.
- 4 Building on the work of Charles Faupel (1987), Grund states that life structures include: regular activities, connections, commitments, obligations, responsibilities and ambitions, which can be drug and non-drug related. He states that life structures also involve general socio-economic, personality and cultural factors.
- 5 The British Crime Survey (BCS) yields imprecise estimates of illegal drug use. The 2002/3 survey estimates that 0.1 per cent of 16–59 year olds used heroin both in the year (occasional use) and month (regular) prior to interview (Condon and Smith, 2003). This makes it difficult to differentiate between occasional and regular use. It also equates to only 30,686 individuals, a figure grossly at odds with other Home Office estimates which suggest there are between 280,000 and 500,000 Class A problem drug users in England and Wales (Godfrey *et al.*, 2002).
- 6 This figure is the medium estimate. The lowest estimate is 281,125 and the highest estimate is 506,025.

- 7 Throughout the report we make reference to dependent and non-dependent heroin use. These distinctions rely on self-assessment by study respondents and not on scores derived from a validated scale of dependency.
- 8 Originally we intended to exclude dependent users from the study, as we felt most forms of dependent use would be problematic in some way. However, as we encountered an increasing number of respondents who regularly used heroin and self-defined their use as non-problematic, it became apparent that this group warranted further examination.

Chapter 2

- 1 This is not case in other parts of the world. In parts of Asia, for example, it is not uncommon for young people to begin their drug careers using heroin or opium (see AHRN, 2005).
- 2 We did not ask detailed questions about an individual's background. Instead we asked about early drug use. The two examples presented in the text came about as a result of these discussions. It is possible that more respondents in our sample had experienced physical or sexual abuse during their adolescence. However, as we did not ask about this, we cannot say for certain.

Chapter 3

- 1 Although we have included monetary amounts and weights reportedly used by our interviewees, it is unlikely that such measures will be standardised. For example,

it is likely that a £20 deal bought from a known dealer will contain more heroin than a £20 deal bought from an unknown street dealer. Likewise, £10 worth of heroin to someone who buys in bulk (a sixteenth or an eighth of an ounce) will be more than £10 worth of heroin to someone who buys half a gram. Rather than being precise, the figures presented here provide an indication of the amount of heroin respondents bought and used.

- 2 This respondent reported spending either £20 or £40 (about a gram) on heroin. He had used heroin for eight years without experiencing a period of dependence. Despite using what appeared to be a large amount over the course of a night, he described the effect of taking heroin as a 'deep warm feeling'. He stated that he would like to experience the feeling of 'oblivion', but could not achieve this from taking heroin. For many non-dependent users, £40 worth of heroin would be more than sufficient to achieve a highly intoxicated state. We believe this provides further evidence that the properties of the drug simply affect people in different ways.
- 3 Binge drinking has previously been defined as the rapid consumption of alcohol over a short period of time. The ONS Omnibus survey defined binge drinking as the consumption of eight units (four pints) or more during the course of a day. Official

definitions have been criticised for failing to account for other factors, such as tolerance and weight. It has been argued that 'feeling drunk' is a better measure of binge use (Webb *et al.*, 1996). This definition of binge use was recently used by a Home Office study of teenage drinking patterns (Engineer *et al.*, 2003). We have applied a similar subjective assessment to establish whether someone's heroin use constitutes a binge.

- 4 Powdered drugs – typically cocaine, heroin and amphetamine – can be snorted. This involves an individual sniffing the drug, often through a straw or rolled banknote, so that it enters the body via the nasal passage.
- 5 'Street methadone' is legally prescribed methadone sold illegally on the illicit market.
- 6 The *Big Issue* is a news and current affairs magazine sold on the streets by individuals who are homeless. It aims to give them a legal source of income and an opportunity to help themselves in their current situation.

Chapter 6

- 1 To avoid the use of discretion generating large disparities in the policing of heroin possession offences, there would need to be appropriate guidance, protocol and safeguards put in place.

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Occasional and controlled heroin use

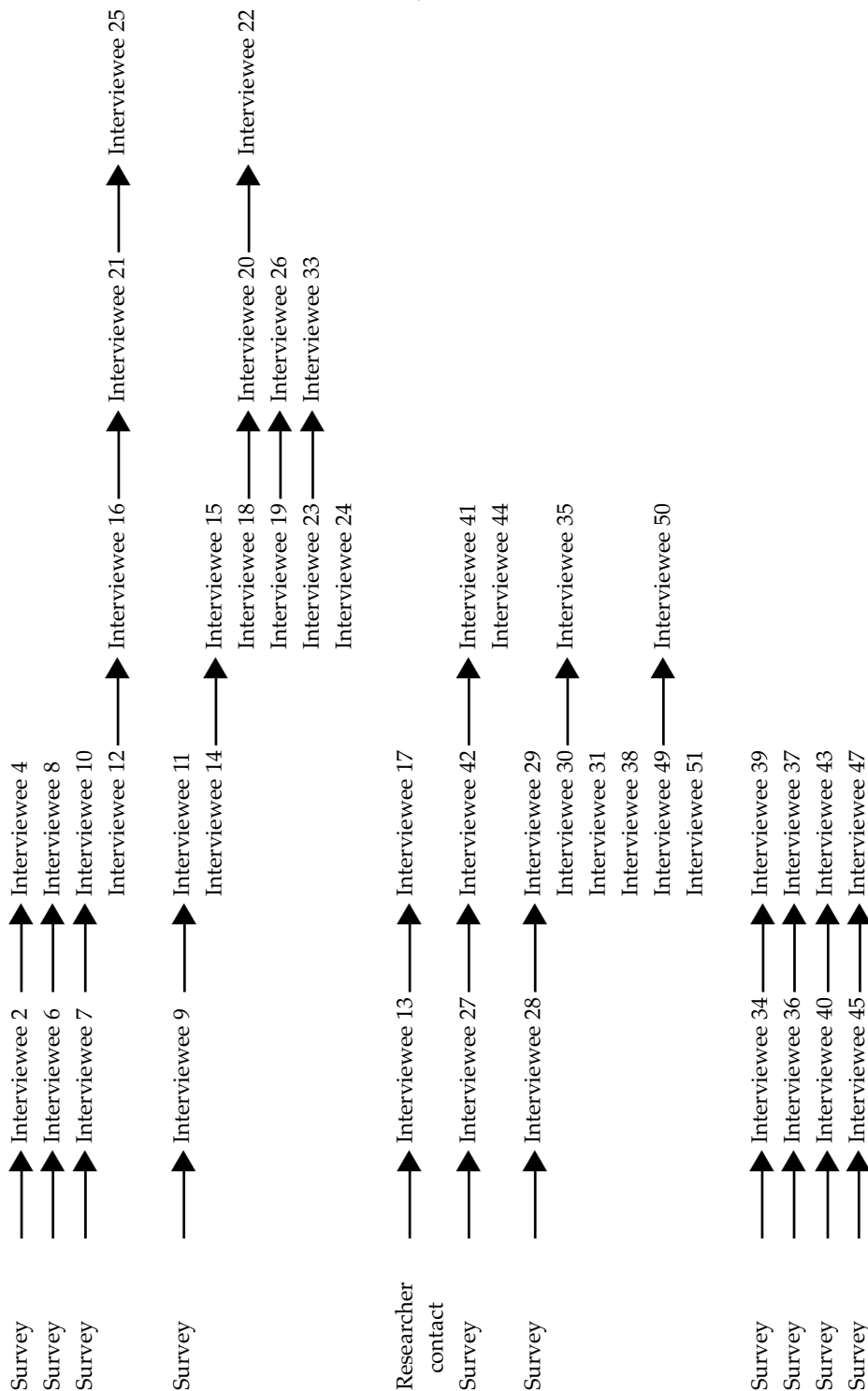
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Appendix 1

Networks of research participants

The diagram below shows how we tapped (or 'snowballed') into research participants' networks of friends and contacts. It shows that rather than tapping into one or two homogeneous networks, we tapped into multiple networks, thus reducing the level of sampling bias.



Appendix 2

Methodology and study sample

Here we discuss our methodology and study sample in greater detail. We begin by outlining our research methods: an online survey and qualitative interviews. We then describe the demographics of the two samples and compare them with research samples recruited from treatment services and the criminal justice system. Finally, we highlight some issues related to the representativeness of the sample, the reliability of the data and sampling bias.

Our methods

We employed two methods to collect data about non-dependent and controlled dependent heroin users:

- an anonymous online survey, which comprised mainly closed questions
- in-depth qualitative interviews.

The online survey

Non-dependent and controlled dependent heroin users are a clandestine, hard-to-reach group. In the majority of cases they will not be in touch with treatment services and will hide their use from those around them. The low visibility of this group makes them difficult to sample (Lee, 1993). Previous research has demonstrated the utility of the internet in attracting hard-to-reach or hidden populations. Coomber (1997), for example, generated 80 reliable responses in an internet-based study of drug dealers. An internet-based study of patterns of ecstasy use in Devon and Cornwall successfully recruited over 400 respondents (Lloyd *et al.*, 2002), whilst we have also

successfully used the internet to recruit a sample of cannabis cultivators (Hough *et al.*, 2003).

Use of the internet has expanded significantly over the past five years. Prior to the start of this study, it had been estimated that 19 million UK residents had direct access to the internet (*Which?*, 2002). More recently, it has been estimated that the number of households with direct access to the internet has increased from 9 per cent in 1998 to 52 per cent in 2004 (ONS, 2005).

Because of the sensitivity of the subject area, our thinking at the beginning of the study was that this group would be keen, at least in the first instance, to retain their anonymity, especially as we envisaged recruiting individuals who potentially had a lot to lose (professional jobs, for example). With this in mind, we felt that the anonymity afforded by the internet made it a useful medium through which to collect data and recruit participants for the second part of the study.

We developed a study website (www.usingheroin.com) and structured an anonymous and confidential online survey. The website comprised a homepage, a page about aims, objectives and study methods, a page about the Institute for Criminal Policy Research, a contact page and a page about the survey (which facilitated access to the survey). At various points across the site, potential respondents were reassured about confidentiality and data protection issues. The survey took between 20 and 30 minutes to complete and was designed to:

- provide a demographic profile of non-dependent and controlled dependent heroin users
- provide background data on drug histories and patterns of use
- provide background data about how use is regulated and controlled
- examine users' perceptions of their use
- test out ideas to inform the qualitative interviews
- recruit respondents for the qualitative interviews.

The single criterion for participation in the survey was having used heroin at least once during the past six months. After piloting the research instrument, the online survey went live in December 2003. We recruited survey respondents by placing adverts in national magazines, sending flyers to universities and treatment services, placing adverts on drug- and non-drug-related internet discussion forums, and through other organisations advertising the study and web address. Although the survey is still running, we stopped collecting data for the report in March 2005. During this period, 246 people completed the survey (see below for discussion about the sample demographics).

Early in the study, we noticed that a number of people were starting the survey but not finishing it. By March 2005, 205 people had started, but failed to complete the survey. To establish the reasons for this, we asked our web design team to create a 'pop-up' box that asked respondents who exited the survey early why they had decided to do so. Once the respondent had entered their reason for non-completion, the

response was submitted to the researcher by email.

Forty-nine (out of 186) people submitted their reasons for non-completion. Twenty people simply wanted to view the content of the survey. This group tended to consist of drugs workers, researchers and other interested parties. Nine people felt that the survey was too long. Six people stated that they had had some form of interruption (for example, somebody had come to their house). Four were concerned that others might see them completing the survey – particularly work colleagues or fellow students. A further ten people provided other explanations: for example, incurring computer problems, the survey having no save-and-return facility, and believing that the inclusion of a fake drug (semeron) was dishonest. We have no way of knowing what proportion of this group completed the survey on another attempt.

The qualitative interviews

In-depth qualitative interviews formed the main body of the research. In particular, the interviews focused on:

- drug-using history
- current heroin use
- where people used heroin and with whom
- strategies for limiting and controlling heroin use
- perceptions of heroin use as non-problematic and controlled
- monitoring use and avoiding related problems

- fitting heroin around life commitments
- views on future use of heroin
- what others thought about respondents' heroin use (family, friends, employers etc.)
- service provision
- views and beliefs about current drug policy.

Using loosely structured qualitative interviews provided flexibility in the interview process. It allowed for interviews to develop on the basis of context and relevance; inappropriate questions could be left out, explanations could be provided and new questions could be added where necessary. Similar questions could be asked in different ways and, where relevant, interesting issues that arose could be probed and investigated further. Having this degree of flexibility also allowed for the research questions to be adapted to the 'comprehension' and 'articulacy' of the respondent (Fielding and Thomas, 2001, p. 123). Importantly, qualitative interviews provided an opportunity to investigate views, beliefs and practices in depth and describe participants' experiences and strategies in their own words. This part of the research was inductive; we adapted our interview focus as initial findings emerged and our understanding about non-dependent and controlled dependent heroin use developed.

Participation in an interview was dependent on:

- self-defining use as relatively problem-free
- having used heroin at least once in the past six months

- not having any current heroin-related legal problems
- not having any significant health problems related to current heroin use.

At the end of the online survey, an explanation about the in-depth interviews was provided. Those who met the criteria for participation, lived in the UK and were interested in taking part in an interview were asked to leave contact details. Potential interviewees were contacted to check they met the criteria and to arrange an interview. Some interviewees were recruited from the online survey (17). Others were recruited by asking participants to pass on our contact details to other people they knew who used heroin in a similar way (37). This technique is known as 'snowball' sampling (see below for a discussion about this).

We interviewed 51 non-dependent and controlled dependent heroin users. Interviewees either were paid £40 or decided to make a £40 donation to a charity of their choice. It is our intention to conduct further detailed analysis of these interview data for publication in social science journals. We also hope to gain funding to conduct a follow-up study of this research sample.

The online and qualitative samples

Using the World Wide Web to conduct a survey of drug use made it difficult to restrict participation to UK residents alone. Our sample of 123 non-dependent and controlled heroin users is a multinational one: 49 per cent were from the UK (61 out of 123), 30 per cent were from the USA and the remaining 20 per cent

were from a variety of other countries – predominantly Australia and Western Europe.

The sample is comprised largely of men (71 per cent) from a white ethnic background (94 per cent), aged between 16 and 60 years (median average 28 years). Although use is spread fairly evenly between those aged 16 and 39, the sample contains a higher proportion of older users: just under half (48 per cent) were over 30, three-tenths (29 per cent) of which were aged between 30 and 39. The majority of the sample were either employed (61 per cent) or students (20 per cent). Only nine people (7 per cent) reported funding – or partially funding – their drug use through crime. Most respondents funded their drug use from their wages (71 per cent) or through various methods not including crime (15 per cent). Another feature of the group is that most reported owning (34 per cent) or renting (34 per cent) their own home or living with their parents (20 per cent). No interviewees reported having no fixed abode. The demographic profile of in-depth interviewees largely reflected that of the web-based sample, as can be seen from Table A2.1.

Comparisons with treatment and criminal justice populations

Previous research on heroin use has typically focused on those in treatment or part of the criminal justice system. The National Treatment Outcome Research Study (NTORS) sample was broadly similar to the sample presented here: it was largely comprised of white (91 per cent) men (74 per cent), the average age being 29 years (Gossop *et al.*, 1998). Differences between the two samples become more noticeable when housing, employment and criminal activity are considered. For example, around 20 per cent of

those who took part in the NTORS were either homeless, or living in squats or temporary hostel accommodation (compared to 0 per cent in this sample). Only 12 per cent of NTORS respondents were employed at the time of interview (compared to 63 per cent), and 61 per cent of the cohort reported committing crime (compared to 7 per cent) in the three months prior to the interview (Gossop *et al.*, 1998).

Information from the arrest referral monitoring scheme in London provides a similar comparison. Of the 2,686 individuals who passed through the scheme between October 2000 and March 2001, 73 per cent were unemployed. The sample's accommodation arrangements were also less settled: 35 per cent owned or rented property, 25 per cent lived with their parents, 12 per cent resided with friends and 12 per cent reported having no fixed abode (Sondhi *et al.*, 2002).

Having or being able to facilitate access to the internet demonstrates a degree of stability in itself. However, those individuals who completed the online survey, and identified their use as problematic ($n = 94$), also showed increased characteristics of a less stable and secure lifestyle. We found an increase in those who stated they were homeless (6) or living in a hostel (2), or described their living arrangements as 'other' (2), while fewer users in this group reported owning their own home (18). Problematic users in this sample were less likely to be employed (44) and therefore less likely to fund their drug use via their wages (29). In fact, a third of the sample reported funding their drug use from crime alone (1), from crime and benefits (9) and through a variety of methods including crime (22).

This comparison of treatment, criminal

Table A2.1 Demographic breakdown of the online and qualitative samples

Demographic characteristics	Online survey (<i>n</i> = 123) (Percentage in brackets)	Qualitative interviewees (<i>n</i> = 51)
<i>Gender</i>		
Male	87 (71)	33
Female	36 (29)	18
<i>Ethnicity</i>		
White	115 (94)	46
Mixed	5 (4)	1
Black	1 (1)	3
Asian	1 (1)	1
Other	1 (1)	–
<i>Age (yrs)</i>		
16–19	18 (15)	1
20–24	24 (20)	2
25–29	22 (18)	6
30–34	17 (14)	16
35–39	19 (15)	7
40–44	11 (9)	5
45–59	11 (9)	13
Over 60	1 (1)	1
<i>Employment</i>		
Full-time employment	60 (49)	25
Part-time employment	15 (12)	5
Student	25 (20)	3
Incapacity benefit	6 (5)	3
Unemployed	4 (3)	7
Other	13 (11)	5
Vocational course	–	2
Retired	–	1
<i>Housing</i>		
Own home	42 (34)	–
Private rented home	36 (29)	–
Rented from council	6 (5)	–
With parents	25 (20)	–
With relatives	9 (7)	–
Other	5 (4)	–

justice and problematic populations highlights obvious disparities with our two samples of non-dependent and controlled dependent heroin users who appear far more likely to be employed, have stable accommodation arrangements and fund their heroin use using legal money.

Representativeness, reliability and sample bias

The following section deals briefly with issues relating to the representativeness of our sample, the reliability of the data and the potential for sampling bias.

Representativeness

Inherent in any strategy designed to recruit participants from hidden populations is the problem of representativeness. We cannot present our sample as being representative of the overall population of non-dependent and controlled dependent heroin users. Neither can we hazard any guess about the size of the population from which it is drawn.

To counter the problem of representativeness, at least in part, we advertised the study specifically to attract a good mix of ages, gender, social, cultural and ethnic backgrounds and geographical spread. We felt that an online survey provided a good opportunity to increase the representativeness of our findings, as the confidentiality assured by the internet would encourage participation by groups who otherwise would have remained hidden. By employing this method though, it became harder for those without direct access to the internet to participate. However, we felt that the benefits associated with being able to reach

such a wide audience outweighed the problems.

Of course, by using the internet we ended up recruiting a multinational sample. Only 61 out of 123 non-dependent and controlled dependent users were from the United Kingdom. This posed certain problems, as different countries have different sets of social, cultural and economic factors that influence the way people use drugs and how they think about their drug use. The biggest problem is whether the findings from this sample can be transposed to a UK context. We felt that they could, bearing in mind two points. First, nearly all the non-UK respondents came from developed Western nations – America, Canada, Australia, or Western Europe – with similar prohibition-based drug control systems. This meant that their using patterns were governed by broadly similar constraints. Second, we only presented findings that could be substantiated by the in-depth interviews, which were conducted solely with participants from the United Kingdom.

Reliability

The length of the survey is one test of reliability. We believed that few people would waste 20–30 minutes completing a bogus response. Nevertheless we ensured that the internet survey contained checks that examined internal consistency. A number of respondents were discarded because they had not used heroin in the past six months (26). Data for a small minority (2) were removed on the grounds of obvious inconsistency: one respondent provided contradictory responses throughout and another began to make ridiculous claims about the things he did for money and the crimes he committed, which rendered his entire response unreliable. Another respondent was omitted

because they consistently claimed to have used the fake drug 'semeron'.

Interviewing someone for an hour or more provides a better opportunity to form judgements about honesty and consistency. We think – but cannot prove – that our sample had little vested interest in deception and are fairly confident about the accounts presented by our interviewees. However, there is always a danger when people discuss their histories that they present themselves in a particular way or so that they fit a particular type. People also construct their narratives in a way that helps them to make sense of their history. At times this may mean respondents – often unintentionally – present self-serving or self-deluding accounts of their heroin use. As this is something that is particularly difficult to identify, we have largely taken our respondents' accounts at face value.

Sampling bias

Snowball sampling taps into a research participant's network of friends and contacts,

and is suited to situations where the use of other sampling frameworks is not possible. We used this technique to recruit qualitative interviewees. It has a number of advantages in terms of accessing hard-to-reach groups. The main one is that respondents are recruited via intermediaries who have participated in the research, and can thus vouch for the researcher's trustworthiness (Lee, 1993). However, tapping into a small number of networks raises the potential for sampling bias: the collection of information from a small number of homogeneous groups that are unrepresentative of the wider population.

Appendix 1 describes the 'snowballing' process. It shows what at the face of it appears to be a number of using groups. This, however, is not the case. With the exception of a couple of sexual partners and a few members of the same using group, most of the networks presented in Appendix 1 consisted of friends, contacts and acquaintances that did not regularly use heroin together. This reduced the risk of sampling bias.

