The drug experience: heroin, part 1

In his latest Background Briefing, Professor David Clark sets the scene for forthcoming Briefings on the heroin experience. He emphasises the necessity to consider the role of drug, set and setting when considering the impact heroin has on lives.

Heroin is the illegal drug that has the worst reputation. The popular press never tires of informing us of new 'heroin deaths'. Government considers heroin to be the cause for much of the acquisitive crime that occurs within the UK. Local officials will often ignore heroin problems in the community because of the stigma associated with the drug.

Heroin is also the drug that myths are made of. In their book *Heroin Century*, Tom Carnworth and Ian Smith point out that no drug has been subject to more misinformation and moral panic.

Here is a drug that is pilloried on the one hand, and yet is used (diamorphine) in the UK without controversy to treat severe and intractable pain, such as that arising from illnesses such as cancer.

It is a drug that is so controversial that when two Scottish researchers published a paper that identified 126 long-term heroin users in Glasgow who were not experiencing the health and social problems normally associated with the drug, there was an outcry from certain circles. Some people considered it irresponsible that such research was published.

In one sense, the first part of the title of this Background Briefing is misleading: 'The drug experience...' There is, of course, no single drug experience, rather a multitude of experiences. It is important to emphasise this point, particularly when considering a drug as controversial as heroin.

Heroin has terrible long-term consequences for some people who try the drug. They become addicted to, or dependent on heroin, and experience withdrawal symptoms when not taking the drug. They reach a point where the drug is more important to them than anything else. They need it on a daily basis in order to function normally.

Their addiction to heroin has many repercussions, which can include a deterioration in their physical and mental health, breakdown of family relationships, loss of employment, housing and material possessions, and participation in criminal offences to fund their habit. They risk overdose, as well as catching blood-borne viruses, such as HIV or Hepatitis C, from sharing needles and syringes.

However, only a small minority of people of people who try heroin take this drastic path. This is clearly evident from statistical data from the US National Household Survey. In the 1999 survey, just over 3,000,000 people were reported to have tried heroin at some time in their lives, but only 208,000 had used in the past month. Therefore, 93 per cent of people who had used heroin had either given up or were not using dependently.

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It is easy to consider drug effects in a simplistic, physiologically pre-determined fashion. However, as we have discussed in various Background Briefings, the subjective effects of drugs are determined by drug, set (*eg* a person's personality, expectancies, emotional state) and setting (the physical and social setting in which drug use takes place). This fact is no less relevant to heroin, than to other drugs that are considered less dangerous.

While some people experience great difficulty in stopping use of heroin, we described a large-scale study which showed that the vast majority of American soldiers who were addicted to heroin in Vietnam, did not show addictive behaviour in the 12 months following their return to the US (*BB*, 21 February 2005).

If we are to understand the factors that underlie problematic drug use and addiction, and help people recover so that they can lead healthy lives, then we need to look at the lives of people who use heroin (and stop or try to stop using the drug). Ethnographic studies dating back to the work of Robert Park and his colleagues in the US in the 1920s have provided important insights.

Chuck Faupel (1991), on the basis of interviews with heroin users in Delaware, talked in terms of heroin 'careers'. He described a career as 'a series of meaningful related statuses, roles and activities around which an individual organises some aspect of his or her life'.

Faupel provided a chart of four common patterns of heroin use which depended on two key elements: the availability of the drug and the underlying structure of the user's life. Structure was considered as a function of the regularity of social networks and patterns of behaviour.

Four types of user were described by Faupel: the occasional user, the stable user, the free-wheeling user and the street junkie.

The street junkie is the type of user most described by the popular press in the UK, the one that most people perceive as being the 'typical' heroin user. The street junkie is the most visible heroin user – and the one most likely to attend treatment services.

The most common route into 'junkiehood' is through lack of life structure. Many people who become street junkies do not have a life structured around conventional jobs and activities, and do not have a commitment to a conventional personal identity, factors which can help keep drug use under control. They commonly lack adequate funds to purchase heroin. In fact, many of these people have had bad life experiences (*eg* social deprivation, long-term unemployment, sexual abuse) before they started taking heroin.

In our next Background Briefing, we will look at the heroin experience from the perspective of people of whose lives have been seriously affected.

Recommended Reading:

Tom Carnwath and Ian Smith (2002) *Heroin Century*. Routledge.
Michael Gossop (2000) *Living with Drugs*. Ashgate.
James McIntosh and Neil McKeganey (2002) *Beating the Dragon: The Recovery from Dependent Drug Use*. Prentice Hall.