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Practitioners' experiences of working with dual users of heroin and crack cocaine. A thematic analysis

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Summary

Background: Crack/cocaine use is highly prevalent among individuals accessing pharmacological treatment for heroin dependency. Quantitative research studies have shown that dual users of heroin and crack/cocaine have worse treatment outcomes in Agonist Opioid Treatment (AOT) programmes compared to heroin-only users, however, no specific psychosocial interventions have been proposed. **Aim:** The aim of this study was to explore the experience of substance misuse practitioners of providing treatment to heroin and crack/cocaine users. **Methods:** The study was conducted in three community services in London, UK. A thematic analysis was performed on semi-structured interviews with seven practitioners from diverse ethnic backgrounds, two females, three currently in leading positions, with an average age of 40 years (27-49), and average work experience of 12 years (2-20). **Results:** Two themes with several sub-themes were identified: The high and the low (Reasons for drug use, Patterns of heroin and crack use, Behaviour); Facilitating change (Worker-client relationship, Working with the drug use, Working with additional issues). The participants highlighted the importance of exploring the use of both drugs, associated personal constructions, and the experience of pleasure. They discussed the medication as a supporting rather than a main intervention, and the need for workers to be creative and skilled in engaging clients with a constantly-changing presentation, using flexible rather than structured interventions. Practitioners identified several patterns of using heroin and crack/cocaine, and discussed suitable interventions. **Conclusion:** Psychosocial interventions need to be better integrated with AOT, and tailored to individual needs according to the pattern of dual use.

Key Words: heroin; crack cocaine; dual use; interventions

1. Introduction

Worldwide, the use of crack or cocaine among dependent heroin users in treatment is not uncommon [2,27,21], and can range to over 70% of users [12]. Quantitative research studies to date have shown that dual users have worse treatment outcomes compared to heroin-only users [12,5,31]. The current UK guidelines on clinical management strongly recommend complementing pharmacological treatment for heroin dependency with psychosocial interventions addressing the crack/cocaine use [14]. However, there remains a paucity of specific interventions addressing both drugs simultaneously. The combined intravenous use of heroin and crack/cocaine and associated risks have been considered in qualitative studies with the aim of informing harm-reduction approaches [30,23], but so far no studies have explored structured treatment for dual users of heroin and crack/cocaine. Practitioners in drug services might have developed successful strategies of working with this group of clients, and their experience could be a valuable resource to inform further research on patterns of heroin and crack use and improve the current practice.

2. Methods

All employees of three community drug servic-

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es in London, UK were approached with the study information. The inclusion criteria were: current or previous substance misuse practitioner with experience in delivering pharmacological and psychosocial interventions to dual users of heroin and crack. The participants were seven practitioners from different ethnic backgrounds (two Black, and one Mixed White and Black Caribbean, Bulgarian, Indian, Chinese, not stated), two females, three currently in leading positions. Their average age was 40 years (27-49), the average work experience in drug services 12 years (2-20), and the average estimated percentage of heroin and crack users on their case load was 61% (50% to 85%). Informed consent was sought before interviewing. All participants interviewed were known to both authors as current or former colleagues. The familiarity encouraged a more informal conversation, making necessary at times additional prompting to make participants' descriptions widely understandable. Semi-structured interviews were audio-recorded with the free App Sound recorder. F.H. conducted and transcribed all interviews which were anonymized before sharing them with M.M. A thematic analysis was conducted according to the recommendations by Braun & Clarke [3]. The analysis was conducted from a critical realist position, assuming that although practitioners' accounts are influenced by several factors such as knowledge or experience, and are thus subjective, they are a true reflection of a reality [32]. The study was approved by the University of Derby.

2.1. Interview schedule

Please refer in your answers to users of both heroin and crack, and not to heroin-only users.

- *How would you characterize a heroin and crack user?*
- *Can you give examples of reasons clients name for their heroin and crack use and how you explore them in your interventions?*
- *How do you work with your clients on their crack use?*
- *What are their reactions to your approach?*
- *Which interventions work particularly well with heroin and crack users?*
- *Which interventions do not work at all?*
- *How do you think the script (AOT) helps them to stop/limit their drug use (both heroin and crack)?*
- *Can you remember any particular heroin and crack using client who made you reflect on or change your practice? Please share your experience.*
- *What do you think is important to consider when working with heroin and crack users?*

3. Results

Two themes with several sub-themes were identified and are illustrated with excerpts from the interviews.

3.1. The high and the low

3.1.1. Reasons for drug use

Pleasure is one of the drivers of drug use which can become so dominant that nothing else matters as much as the drug use, *nothing else is as interesting and as exciting as the drug use (P1).*

Even the use of other drugs can become a means to enhance the pleasure given by crack/cocaine:

Crack is their main source of enjoyment in terms of the drug use, and everything else they use [heroin, benzodiazepines, other depressant drugs] it's a kind of self-medicating, to come down [...] kind of trying to negate some of the bad sides of using crack (P6).

Drug use can be a choice for diverse reasons: *if there was heroin alone they say they are doing it not to be sick (P6),* to enable them to do other rewarding activities they feel unable to do otherwise because they lack self-confidence: *'it makes me … do things I would never do if I'm … not on it.' [...] one client has said even to approach a girl. (P4)*, or as a coping mechanism with past trauma or other life issues:

I think one of the main reasons is mental health and self-medication. […] the only thing that gives them that ease of what is happening within the mind is the drug. [...] You have mental health, you have abuse, a lot of childhood abuse, domestic abuse, a lot of shame and guilt, and escapism [...] I remember one client of mine saying: 'Why are you trying to … heal me? Why are you trying to take me off this drug? When my life is dirt, so you want me to be sober to look at my life?' (P4)

However, practitioners also described situations where the drug use seems to be imposed by social circumstances and one's own vulnerability:

I feel that a lot of people are introduced to dual use from dealers offering two for one deal, so they get one [bag] of each [heroin and crack] for the price of one […] I get a sense that clients feel coerced, or it is not their desire to use the crack, they just …. it's forced upon them by the dealer. (P2).

They [homeless users] want somewhere to stay

for the evening or for the week rather than staying on the street and then … they are expected to come in with some heroin and some crack that they share around (P6).

3.1.2. Patterns of heroin and crack use

Some users alternate the two drugs. The order is not arbitrary but purposely chosen to enhance the enjoyment of their 'drug of choice':

Some users, use heroin first. And they say they do that because it increases, … or they notice the stimulant use a lot more when they smoke crack (P2)

Because the heroin users, my understanding, they want to feel the sedative effect [of heroin], but they can't do [because they have a tolerance], so they use the crack [first] to feel the sedative effect (P3).

The alternating use of drugs with opposite effects can be enjoyable, because it creates contrasting pleasurable feelings:

'I use one to counteract the other' […] I think the main thing is the pendulum kind of depressants and stimulants just going tick tocking almost. (P3)

The pattern of heroin and crack use is dynamic, the focus on one or the other drug can change with circumstances:

A lot of times, people start using crack and someone will tell them that [using heroin after] it's a better way because coming down off crack is the psychosis, […] And they will try the heroin and they will get better come down, but then the drug switches. And next thing you know most crack users say: oh I only started off with crack and now I'm addicted to heroin! And the heroin becomes the dominant … (P4).

Not everyone alternates between heroin and crack use; some people prefer to use them simultaneously. The drugs combination is not necessarily injected as a 'speedball', but can be smoked on a pipe. Regardless of the route of administration, this combination results in a psychological attachment to both drugs:

The clients I come across now are using both on a pipe, which is like speedballing when it's injected, and it's a bit more difficult to separate, because they see the hit as one (P5).

3.1.3. Behaviour

Dual users of heroin and crack are *quite isolated from society, quite erratic within that close community, and prone to having lots of risky situations (P2)* and their behaviour when attending the treatment service mirrors their drug-taking behaviour.

This urgency was compared to a situation prompting checking for immediate risks: *there has been heroin and crack users who have come in … in what initially would feel like a crisis (P1),* especially for those using drugs intravenously: *the physical [health] complications are far greater and [...] risks all over, the use of the drugs is far greater for people who IV [use intravenously] both crack and heroin (P2).*

Dual users behave unpredictably: *Some people …. are little bit less chaotic than others, but the majority of them come in as chaotic (P4),* and working towards change is a challenge for practitioners because *they [clients] are in that zone where there is no other life, and there is no other alternative (P2).*

Not only achieving but also maintaining change is challenging:

I've seen some of them progressing quite well, and then due to change in circumstances they somehow feel overwhelmed, and incapable dealing with it (P1).

These difficulties are reinforced by a reduced cognitive capacity induced by the pharmacological effects of the two drugs:

you imagine, a heroin and crack user comes in sedated, other times he comes in banging on the walls (P3) and is unable to engage in therapeutic conversation with the practitioner: *I would have the attention of a dual user for… possibly 15-20 minutes (P2), [...] because the crack in itself raises my [client's] anxiety, it raises, you know, my adrenalin and so, so sitting there and listening to someone [the practitioner] go on, and on, and on is not the best thing (P4).*

However, although clients describe their using behaviour as an automatic reaction out of their control, the practitioners recognise a whole cognitive process behind it:

*'oh, I had to use' … I ask: how did that happen? 'Oh I don't know, has just f**king happened.' Like it's magic, or something. It's not magic, it's been a … series of events that have led up to that crack use. (P3). There are stages, they'll have a thought… There could be a pre-planning of a couple of days ago (P2).*

3.2. Facilitating change

3.2.1. Worker-client relationship

The participants spoke about the importance of creating a space where the client feels accepted and valued in order to encourage the engagement in therapeutic interventions. This is achieved by being non-judgemental:

I am genuinely curious about, you know, why they are doing things and where they are. (P1)

Service users know when they are being judged [...] it's about the language that we use, I never, ever use dogmatic language i.e. should, better, must, ought to, have to. Because it's language that can get people's back up, it's language that can elicit old memories, you know, almost bad parenting, or schools where they did not have a good time. [...] one word I might say 'you must' which accounts for, I don't know, 2% of what I've just said, but that's what the client will remember. (P3)

Contrary to the widespread belief that having been through drug use and treatment makes someone a better practitioner, one participant explained that *[clients] want to know that you empathise with them, and not so much that you had had personal experience, but they want to know that you've got good understanding of the issues that affect them. (P3)*

The participants were also aware of the ways both parties shape the interaction. The practitioner can only work with what the client brings into the session: *I'm only being presented with what the client wants me to be presented with (P1).* At the same time, the practitioner is in the position to influence the client's expectations from the treatment:

It depends on what you cultivate at the first presentation […] So if they [clients] feel that if they come in they're only going to get a prescription, no interaction or anything like that, then that's what they are going to want to get: 'I'm coming in for my prescription'. (P4)

Generally, considering the unpredictability in behaviour, the risks and the very likely intoxication, when working with dual users of heroin and crack *the practitioner needs to be flexible and be able to draw on all interventions to deal with whatever comes in that situation that this client group is going through. (P2)*

3.2.2. Working with the drug use

An important step is the exploration of the benefits each person gets from the drugs they use in the preferred pattern and in the context of their life: *you have to look at the high, the actual effect that both [drugs] are giving to him (P5), trying to get an understanding of when they use the heroin and how they use crack, and how they are put in place (P7).*

AOT is a tool to reduce the drug use. Although pharmacologically designed to address the heroin use, it can have an indirect effect on the crack use and exposure to drug-seeking activities:

your daily interactions with the dealer can be reduced. And because we know, a lot of dealers sell crack as well as heroin, it may have a knock-on effect on their crack use. However, a script on its own will not take away the cravings for the crack. (P3)

The prescription could also help separating the two drugs, allowing the therapeutic work to address only one drug at a time:

I have clients who are stable on script, motivated, so they are not touching any heroin, and now working on their crack use. So in that respect [the prescription] is a support [...] to give them some stability, and a sense of achievement [...] it allows them then … to isolate the crack use and work with that (P1).

This does not work for everyone, and when dual users continue using both drugs despite being on medication, behavioural interventions can be used to disentangle the attachment to both drugs as one. For example, drug separation can be achieved by helping a user to change the route of administration for at least one of the drugs to a less harmful one:

It's about getting the client separating both […] I think it's important looking at … smoking crack and then smoke heroin or smoke the crack and inject the heroin [instead of injecting both] (P5).

In addition, practitioners found it important to question the explanations given by clients for their drug use, and engage them in a process of de-constructing their beliefs around their using behaviour:

They say they try to hide away from their emotions, not thinking about how rubbish their life has become, but once we explore what their lives have become because of the drug use in the first place […] they think 'OK so I'm using because my life is rubbish', and they say 'my life is rubbish because I am using', so it's trying to get them out of that cycle (P6).

So obviously a part of you, the client, wants to use that crack. And I want to talk about that part of you that wants to use the crack. And I'll go into what their emotional attachment to crack is, [...] so if [crack] helps them to do this, or it allows them to do that […] I identify that, and I show them a way to take back that power (P2)

The participants discussed the process of identity reconstruction as crucial for making durable changes, because *the drugs will one day define the user's own self, their identity: their drug use and who they are have sort of become one. So they are their drug use, and they cannot be without it because who are they without it? (P1).* The practitioner can help clients to distance themselves from the 'addict' identity by ex-

ploring *who they are beyond their drug use […] and what they want to be, what makes them them. (P1).*

Drug users are encouraged to develop a new identity by actively enriching their lives with additional meaningful activities, minimizing the role played by the drugs in their life:

It would be nice if they could find things outside [the treatment service] as well, not just leave it to us, because it's important for them to think of themselves as more than just users, it would be nice if they'd realised and not identify as addicts, and do something completely different (P6).

3.2.3. Working with additional issues

In addition to the drug use, clients present to treatment services with a series of additional needs which practitioners feel responsible to address, such as physical and mental health problems, social, financial or familial issues, and past or current trauma:

We do a bit of health promotion with people around the benefits of exercise, how it can affect your mood, how it can affect health, problems with depression, and things like that (P6).

Although the AOT helps to bring stability and ease into clients' lives, the medication is still another psychoactive drug being added to the picture:

if they are homeless and they are living on the street, things are really bad, nothing is going right for them […] the script it's helping them survive a lot more, … but you're introducing another high to them (P5).

Furthermore, reducing other struggles in people's life with medication can become a double-edged sword because it reduces the immediate urgency to stop using drugs, and so the motivation to invest effort in developing coping skills:

I think [the prescription] it's just another … problem, it's just another excuse, a reason. […] people have an attitude with it: you owe me, you are lucky I am on a script, so you can't say no to me. But we're not here to say no, we're here because we want you to understand it […] [coming off drugs] is about their own responsibility, but they are not using any of their brain power, they're just relying on something else. (P7)

It also allows occasional drug use without the urgency of getting heroin several times every day, so now the drug use is perceived by clients as their choice and not 'forced' by the withdrawals:

[for some clients] the opiate script seems to be more something they use to … provide themselves with that security that 'if I am not able to get the drug I still have … enough to get me through' (P1).

4. Discussion

This study explored practitioners' views on adequate treatment for users of heroin and crack/cocaine. The participants described dual users as isolated, chaotic and displaying a sense of urgency in their behaviour. Several reasons for drug use were discussed such as pleasure, coping with opiate withdrawal or emotional trauma, and enabling other pleasurable activities. Good engagement of clients was seen as crucial, as well as openly talking about the high given by the specific combination of the two drugs. AOT was considered as a harm reduction approach that works only if complemented with appropriate psychosocial interventions addressing the pattern of drug use rather than the two drugs separately.

Some practitioners named as reasons for drug use those already described in the literature: curiosity and experimentation [19] and self-medication of trauma and mental health in consonance with Khanzian's hypothesis according to which drug use is a way of regulating unbearable emotions [17,22,13]. However, others considered the pursuit of pleasure as the only reason people use drugs, while any other reasons named by clients being justifications for further drug use. This is in agreement with the stance adopted by Robinson & Jordan in their Resonance Factor therapeutic model, which aims to engage clients to deconstruct explanations of drug use implicitly adopted from the social, medical or political discourse, and explore the attachment to the drug(s) of choice similarly to the attachment in a relationship [25]. The relevance of pleasure experienced by drug users and the importance of its exploration in psychological treatment and harm reduction are not new ideas [29,7,15]. Combining these contrasting views, Griffith et al. distinguished between 'primary addiction', when enjoyment drives the drug use, and 'secondary addiction' when the drug use is a consequence of an underlying psychological imbalance [9]. However, they do not need to be exclusive: 'correcting' a negative psychological state is similar to pleasure, because enjoyment and detachment from reality results from contrasting feelings [6].

Practitioners highlighted several ways in which users combine heroin and crack, and suggested that the treatment needs to be adapted accordingly. The pleasurable feelings given by drugs are driven by neurobiological changes in the brain [24]. Some theories such as the Unified Theory of Addiction [33] have

proposed that the mechanism underlying the compulsive drug use, considered to be a marker of addiction, is independent of the drug's specific pharmacology. However the participants expressed the opinion that drug taking is an individual experience, and users will have specific preferences for drugs and/or drug combinations: Furthermore, they explained that patterns can change with circumstances, so are not static as previously described in literature [18]. The AOT helps some dual users to stop the heroin use and isolate the crack use to be addressed in psychosocial interventions. However, for other users the two drugs are experienced as one, and the pharmacological intervention only reduces the drug use all together but does not separate the two drugs. This suggests that psychosocial interventions directed at the crack use alone might not work for everyone.

AOT was seen by participants more as a harm-reduction intervention, some of them being negative about it, comparing it with another high which does not allow people to work on life issues, and substitutes not only the physiological withdrawal, but also the pleasure otherwise provided by heroin. Apart from reduction in drug use and stability, AOT has other proven benefits not mentioned by the participants, not least the significant reduction in fatal overdoses [14] and the fact that clients engaged in treatment have frequent contact with health services, allowing for faster recognition of related or unrelated health issues. However, if someone's treatment aim is abstinence, it is important to work on the psychological attachments to the drug combination of choice. The attachment to a substance can be seen as a cognitive learning process, which is aided by the drug's rewarding properties [8]. While AOT is helpful in numerous ways, without adequate psychosocial and behavioural interventions, it can in itself reinforce that drug use does not have immediate negative effects, as the AOT masks the withdrawal triggered by occasional heroin use. This suggests that practitioners and services have a responsibility to make sure that AOT is used for its benefits and does not become another substance clients become attached to, and a barrier to change.

An interesting point raised by practitioners was related to situations where the drug use is seen by clients as determined by third persons or external circumstances. This was discussed according to the Resonance Factor approach as an unacknowledged choice that serves the purpose of justifying more drug use. The perceived automatism of such behaviours, can be also seen through the perspective of Kahneman's theory of thinking: in most situations 'System One' is active, which is an intuitive, automatic and emotion-driven thinking based on behaviours learned and practiced regularly. The reflective 'System Two' is logical but time-consuming and is generally only activated for complex tasks, including learning processes [16]. To create new habits integrated into 'System One', a sustained learning process is required. According to Social Learning Theory, people learn from one another in a social context via imitation, observation, and modelling [1], and internalise discourses available in our culture and society [4]. Being a drug user means often being isolated within a stigmatized community. This stigma, internalised through identification as member of this community and the emotional value given to this affiliation [28] leads to construction of the self as a negative person [11,20]. Participants talked about using interventions aimed at identity reconstruction not only to put the drug use in perspective but also to create a distance from social constructions associated with drug use.

Drawing on Ian Hacking's concept of 'Making up people' [10] Toby Seddon explained that the 'Problem Drug User' was introduced in 1982 by the Advisory Council on the Misuse of Drugs as a reaction to the HIV epidemic, and to justify a governmental policy change from the abstinence-based model to the harm reduction approach [26]. He further commented that although there were heroin users experiencing health and social problems related to their drug use before 1982, a 'Problem Drug User' was not how people defined themselves nor how they were perceived by others. This highlights the role of society, and that beyond the interventions at individual level such as those discussed by participants in this study, there is scope for societal interventions to reduce stigma and isolation to support the individual change.

Limitations

Similarities between participants' views could be partially explained by the fact that they were working for drug services run by the same provider, at the time of the interviews. They had access to similar training, for example the resonance factor approach was known to some of them. However, most of the participants had worked for different providers in the past, and they had diverse educational background and professional qualifications.

5. Conclusions

In conclusion, the interviewed practitioners considered that for dual users of heroin and crack: (1) AOT is a significant tool, but it is not sufficient for achieving abstinence; (2) A flexible approach works better than structured interventions, and the focus needs to be on the pattern of heroin and crack/cocaine use; and (3) Workers need to be creative and skilled in engaging clients with a constantly-changing presentation. These insights can inform further research and developments to improve the practice in drug services.

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Contributors

F.H. managed the literature searches, conducted and transcribed the interviews, and wrote the first draft of the manuscript. Both authors were involved in the study design, data analysis (coding and theme definition), discussion of the results and manuscript revision.

Conflict of interest

F.H. declares no conflict of interest. M.M. was involved in the development of the Resonance Factor approach.

Ethics

Authors confirm that the submitted study was conducted according to the WMA Declaration of Helsinki -

Ethical Principles for Medical Research Involving Human Subjects. The study has the approval of the University of Derby, UK.

Note

It is the policy of this Journal to provide a free revision of English for Authors who are not native English speakers.

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