Practitioners' experience of working with dual users of heroin and crack in community drug services. A thematic analysis

Felicia Heidebrecht[1] and Mary Bell Macleod[2]

[1]London South Bank University, [2]Camden and Islington NHS Foundation Trust

Background

The high prevalence of crack use among individuals accessing pharmacological treatment for heroin dependency has already been documented more than a decade ago, and it is still on the rise in the UK. Quantitative research studies have shown so far that dual users have worse treatment outcomes in opiate substitution therapy (OST) programmes compared to heroin-only users. Nonetheless, 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 to help improving the general practice and treatment outcomes.

Aim

To explore the experience of substance misuse practitioners working with heroin and crack users.

Methods

Setting: Three community drug services in London, UK

Participants: Seven practitioners of diverse ethnicities, 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).

Data collection: Audio-recorded face-to-face semi-structured interviews exploring participant's views on the particularities of heroin and crack users, and their practice with this particular group of clients

Analysis: Thematic analysis (Braun & Clarke 2006)

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) and Facilitating change (Worker-client relationship, Working with the drug use, Working with additional issues). Examples of participants' quotes are represented below.

The high and the low

Reasons for drug use

'it makes me ... do things I would never do if I'm ... not on it.' (P4)

[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).

nothing else is as interesting and as exciting as the drug use (P1).

crack as their main ... I think the main source of enjoyment in terms of the drug use (P6)

a lot of people are introduced to dual use from dealers [...] 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)

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)

Patterns of heroin and crack use

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).

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)

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)

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)

Behaviour

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).

Quite isolated from society, quite erratic within that close community, and prone to having lots of risky situations (P2)

*'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).*

they are always in a rush ... I suppose that ... that behaviour of their next hit, I want ... I'm here, I want that now, I need it now, not able to slow down, not having any structure, not having any boundaries (P7)

I would have the attention of a dual user for... possibly 15-20 minutes (P2)

Facilitating change

Worker – client relationship

Service users know when they are being judged [...] it's about the language that we use, I never, ever, 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)

They all 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 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)

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)

I am genuinely curious about why they are doing things and where they are (P1)

Working with the drug use

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)

Trying to get an understanding of when they use the heroin and how they use crack and how they are put in place.(P7)

you have to look at the high, the actual effect what both [drugs] are giving to him (P5)

[on OST] 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)

So obviously a part of you, the client, wants to use that crack. 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)

I have clients who are stable on script, motivated, so the 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).

Working with additional issues

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)

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)

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).

Discussion

The participants pointed out the importance of exploring the PATTERN of drug use, including associated personal constructions. Furthermore, they discussed the medication as a supporting rather than a main intervention, and the current treatment approach as a way to reduce harms rather than to achieve abstinence.

Conclusion

The interviewed practitioners considered that for dual users of heroin and crack:

- **OST is a significant tool, however not sufficient for achieving abstinence;**
- **A flexible approach works better than structured interventions; the focus needs to be on both drugs;**
- **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 practice in drug services.

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Email: felicias.research@gmx.de

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