THE SOUTHCROSS PROJECT
Practices and Processes
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An exploration of drug misuse, treatment and aftercare and the processes involved.

Kim Etherington PhD and Emma Barnes MSc

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Kim Etherington and Emma Barnes.
INTRODUCTION

‘...we arranged to see a number of local people to get their opinions – some of them didn’t want to know. They were up to their teeth with what drugs were doing to the community so they felt that a drug project in their midst would just add to the problem. So we tried to help them to realise that by doing something positive about it that needn’t be the case. We had no money, no premises - just an idea really to create a project.’ (Mike Peirce, Chief Executive of Southmead Project)
BACKGROUND TO THE STUDY

The Southmead Project (SP) was set up twelve years ago in response to the increasing problems with heroin and other drug misuse in the local area and has provided harm reduction, outreach and methadone substitution support programmes, as well as helping clients to find training and employment. Over half of the local residents surveyed in 2002 (1) identified the SP as having made an important contribution to an increased sense of safety in the area.

It has long been recognised that stabilisation through methadone substitution can improve family relationships, public order and economic productivity (2) and thereby impact positively on individuals and the local community. However, methadone in-patient detoxification has been found to be generally unsuccessful, with relapse being the norm upon return to the community (3). An alternative method of treatment delivery is provided through primary care services, where the client remains in the local community whilst being prescribed methadone by their local GP with support from specialist drugs agencies such as The Southmead Project. While acknowledging community treatment as a valuable therapeutic intervention (4), local residents may still be concerned about the impact of intoxication, violence and the street-drugs market that may accompany community treatment centres (5). For clients receiving treatment in their local community difficult environmental conditions (6) and the complex intergenerational nature of their drug problems means that prospects for successful treatment remain poor (3).

The SP recognized early on that simply driving drug users out of the area was not solving the drug problems: drug users needed to be cared for and re-integrated into the community. As a local agency SP believes it can offer an understanding of the area that other non-local agencies, may not (7). The ethos of SP has been to enable members of the community to help themselves, as an early strategy statement put it -

“It is important for a service to be available locally, both for users and their families, and for there to be an effective education programme in the area. The strength of the Southmead Project is its energy, and its ability to mobilise local people with its community approach.” (The Southmead Project Strategy for the period October 1995 to March 1997, p.3)

In recognition of environmental and intergenerational complexity surrounding drug misuse staff at the SP have approached their work with a desire to understand how those factors contribute to the problematic use of drugs within their local area, believing that such an approach will enrich understanding of the whole person rather than the drug problem alone.

The study, of which this report is one part, was commissioned by The Southmead Project and had two main aims: The first aim is:

To explore a range of views on the services provided by the Southmead Project to gain an understanding of
addiction, treatment and aftercare and the processes involved.

Within the limited funding available for this research it was decided that the main thrust of the study should examine the views of those involved in the methadone programme. In the period since this study was commissioned, indeed almost at its completion, funding allocated to SP for their work supporting methadone users has been withdrawn and reallocated to a non-local organization. However, the understandings gained by examining one organisation from the point of view of those using and delivering the services, can be applied in other organisations, a fact that was acknowledged by the Audit Commission Report (8).

The second aim is:

To examine potential links between drug misuse and historic abuse/trauma in the lives of drug misusers.

The SP, like many other agencies working with drug misusers (and indeed many other generic counselling services), has recognized that historic abuse and trauma often underpins the life stories of their clients. In response, SP has created a specialist service to deal with underlying abuse/trauma issues once the clients’ drug misuse is under control. Although there seems to be a great deal of anecdotal recognition of the links between drug misuse and underlying trauma and/or abuse there has been little research that deepens our understanding of how trauma/abuse is linked with subsequent drug misuse. With this knowledge it would be possible to plan appropriate, and perhaps early, interventions that help prevent the slide into drugs and thereby reduce the costly personal and social price that is currently being paid.

**Previous reports**

Three reports formed the background to this study. The first report *Southmead: Is it getting better* (1) illustrated some of the positive and negative aspects of living in Southmead as reported by local residents and those who are working to improve the area. The second report *A Review of the Bristol Shared Care Scheme* (2004) (9) was a review of local services, with the focus on GPs and Pharmacists’ involvement as well as drugs agency staff and clients. The third report *Drug Misuse 2004: Reducing the Local Impact* (8) carried out by the Audit Commission examined how the national drug strategy is being delivered in local areas.

_Southmead: is it getting better? An evaluation of Community Safety Initiatives_

Working as part of the Community Safety Team at the University of the West of England, Bristol, Shaftoe (1) published a report outlining how the local and national media had maintained the negative public view of Southmead as a rough neighbourhood, which dissuaded outsiders from moving in or investing in the area. The media, were also reporting some of the very real problems of Southmead. In the Bristol Safer Cities Project and the 1998 Audit of Crime and Disorder Southmead was ranked as a ‘priority area’. In 2001 Southmead had the second highest rate of referrals to Bristol Social Services department and the fourth highest proportion of children on the child protection register in
Bristol. In the mid 90s heroin use and dealing was beginning to have a huge adverse effect on the Southmead estate and the widespread abuse of local children was linked with one of Southmead’s heroin dealers who was convicted and imprisoned, leaving behind a trail of devastation in the lives of young people in the area. Southmead also had the second highest proportion of under-16s in Bristol, which meant there was a large number of children experiencing trauma, deprivation and lack of opportunity.

By 2002 there was a belief that Southmead was stabilising, with less chaos and disorder than before. Two Council-run tenant satisfaction surveys in 2000/1 and 2001/2 found that complaints about vandalism and drug dealing were reduced. This change was attributed to local social and physical initiatives. The two initiatives that received most praise were The Voice of Southmead and The Southmead Drugs Project. The Voice of Southmead was initially set up by locals to drive drug dealers out of the area through ‘name and shame’ leafleting, and local people, recognising that young people on the estate needed an alternative to drug use, set up sports groups and worked with the police to help convict drug dealers.

However, Shaftoe reported that 'druggies' were still seen as a significant problem on the estate and young people reported that heroin and cannabis were easily available, with cannabis use being the more acceptable of the two. In 2001 the Southmead Youth Project Partnership survey found that 91% of those surveyed believed Southmead was a ‘drug problem area’.

Youth and health workers were optimistic about the area as they reported that the younger residents of Southmead were not graduating onto harder drugs, preferring instead to use alcohol and marijuana as intoxicants. Heroin users tended to be older residents who smoked rather than injected the drug and were perceived as 'losers' by the younger residents. There was praise for the improved services and enforcement agencies that were tackling drug use and drug dealing in the area. However, at the same time it was felt that drug use and dealing, and domestic and child abuse were becoming more visible within the estate, possibly as a result of improved access to support services (e.g. Touchstone, an abuse counselling service set up by the SP).

The services being offered in the area tended to be run by skilled local people, which helped foster trust and mutual respect:- Southmead having a large number or long term residents with extended family and friendship networks. Shaftoe’s report recommended the need for: better support for parents of drug users, earlier interventions to help prevent child abuse; and more long term work with drug misusers to prevent relapse.

**Review of the Bristol Shared Care Scheme**

In 2004, in response to strong media criticism, research was commissioned (9) to discover how the different elements of shared care operate as a whole in Bristol. The report suggested that there were several benefits to treating drug abusers in a primary care setting rather than as in-patients. The first was that general practice facilities are more accessible and widely available as compared to the limited access to in-patient beds, and that by...
seeing a GP or other care staff on a regular basis, the client is more likely to receive long term support for their drug misuse and other associated physical or mental health needs. The fact that clients present themselves to GPs for help suggests that they are aware of their problematic drug use and already motivated to engage in treatment. By remaining in their community clients can build up a 'normalized' view of themselves and by the same token others are also able to view them as primary care users like themselves.

The report referred to the work of Gabbay, Jeffrey & Carnwath (12) who found that some of the main successes of this type of treatment include long term engagement of clients leading to improvements in health status over time and addressing the "whole needs of the individual, physical, psychological and social"; reductions in illicit drug use; drug related deaths; and criminal activity; and an increase in the likelihood of finding employment. The need for flexibility and tolerance of minor lapses was emphasized, alongside the matching of therapeutic interventions to the client's needs. The need to treat the whole person required the inclusion of specialized support.

The review of the share care scheme involved interviews with GPs, pharmacists and clients about the services provided. GPs reported a genuine concern for the clients' needs and were interested in new ideas of practice.

Most of the GPs surveyed had adopted a flexible approach to care in order to retain clients, while still focusing on reducing dosage. This flexibility was important because 77% of the clients surveyed disclosed that they had topped up at least occasionally within the last 12 months. Both GPs and clients sometimes interpreted flexibility as being inconsistent practice across the scheme. Some clients complained of an inconsistency around urine testing, saying there were elements of a 'postcode lottery' around treatment, and that this inequality may be associated with differing outcomes.

Many clients also praised the services that they had received and some felt that their GP or drugs worker had saved their lives. The quality of the relationship that they had built up with their drugs workers was appreciated, in particular the level of honesty that they could demonstrate in their sessions. Some clients viewed the scheme and the need to keep appointments as providing a positive structure to their everyday lives.

**Drug Misuse 2004: reducing the local impact**

The Audit Commission's (8) report examined the delivery of the national drug strategy; data were collected from nine English and Welsh Drug Action Teams, community safety partnerships, local health boards, drug user and carer agencies and a review of current literature. They found that clients typically sought help after a personal crisis in their lives, through the active encouragement of someone close to them, or through referral by the Criminal Justice System after arrest. Once they had made a request for help, a speedy referral to a treatment regime was needed in order to maintain motivation and self-confidence. The involvement of partners, children or parents in treatment was also thought to have a positive effect. The clients surveyed also reported problems combining their treatment with their everyday lives: for example, inflexible
appointment systems and limited opening hours. This finding is worrying in the light of recommendations made by the Audit Commission in 2002 (13), that services should match users’ needs in order to avoid the persistent ‘revolving door’ clients.

The report found that factors associated with successful treatment outcomes were:

- long term and continuing support of clients after treatment;
- access to help with other areas of their lives, such as education, employment and housing;
- and access to local support groups.

The quality of the relationship with staff was also highlighted as an important factor in successful treatment outcomes, with negative attitudes from staff being reported as a main reason for not continuing with treatment.

**Strengths of primary care and recommendations for practice**

All three reports recognize the need for long-term support in drug rehabilitation. Aftercare should not be restricted to helping clients avoid relapse, but should also include assistance with other aspects of the client’s life. A flexible and client-centred model of treatment was recommended in order to meet fully the complex needs of individuals; therefore the support should include individual, physical, psychological and social support (12). Positive relationships with staff members were valued by clients and are thought to be essential in determining the success of treatment (8).

While the three reports looked at the quality of service provision from the points of view of the local residents and the GPs providing the services, there was limited use of clients’ voices.

It is acknowledged that the pathway to problematic drug use is a complex combination of multiple biological, psychological, cultural and environmental risks and protective factors (14) yet only a small percentage of research is concerned with the clinical, social or psychological correlates of drug use (15). Research has tended to focus on the characteristics of the individual client in treatment rather than the characteristics of the treatment itself (16), or how clients received that treatment (17).

Workers in the drug treatment field have now accepted the need to study the therapeutic process in order to understand how treatment works and why clients frequently relapse (18). The main questions to be raised are about what is going on during the process itself - how the treatment organization affects the clients, i.e. the interactions between clients’ different needs, the treatment interventions and ideologies of the organization (19). Whereas it is commonplace for the views of service users to be sought in many areas of health and social care service delivery, this is less often seen in the provision of drug treatment (20). Here, professional perspectives, resource availability and funding priorities have more influence over the provision of drug treatment than clients or local people affected by drug misuse (21) (22).

With these limits in mind a major part of our study will be to conduct and publish a narrative inquiry in Autumn 2006 to re-present in-depth the life stories of eight ex-drug misusers, which
will create a powerful and rich contribution to the literature.

Lilly, Quirk, et al (17) outlined key issues that need to be addressed in future research into methadone treatment. Their main point was that research has generally ignored the wider social aspects of methadone treatment and how clients’ view their relationship with clinical staff. Clients reported that they appreciated having a good relationship with their drugs worker, but the ability of the drugs worker to maintain good relationships with clients can be affected by the relapsing nature of opiate misuse, it is therefore important to focus on how these tensions are managed in treatment delivery. The social aspects of methadone treatment delivery can affect clients’ treatment engagement and their treatment outcomes.

THE STUDY

This report is based upon research designed mainly to address the first of two aims:

To explore a range of views on the services provided by the Southmead Project to gain an understanding of addiction, treatment and aftercare and the processes involved.

In consultation with Mike Pierce (Chief Executive of the Southmead Project) and other SP staff members, service users, local GPS and other surgery staff, it was decided that a qualitative approach would best provide in-depth understandings. This aim would be met by using traditional qualitative interviews with a thematic analysis.

Papers from this arm of the study have been delivered at a conference in Glasgow in May 2006 (BACP Research conference), and will be written up for publication.

The second aim, to show how ex-drug misusers themselves understand potential and actual links between their early life experiences and subsequent problematic drug use, is being addressed separately using the life story approach previously mentioned. Those life stories are being collected from outside the local community in order to preserve participants’ anonymity. Details of a person’s life that are known within their local community can lead to their identification when using narrative inquiry. The findings from the narrative inquiry will be published in a book in 2007, entitled: ‘Trauma, Drug Abuse and Transforming Identities: a life story approach’, for which a contract has been signed with Jessica Kingsley Publishers. Several academic papers relating to this work in progress have been written by the lead researcher and two have been accepted for publication in international peer-reviewed journals (23), (24).Further papers are under review.

Methods used

The views of methadone clients and of the staff who provide support services were gathered through a combination of questionnaires and semi-structured interviews. Relapse prevention group members’ views were gathered using a group interview and individual semi-structured interviews.

The research was mainly conducted by a paid researcher who was assisted by a team of qualified volunteer researchers who undertook some of the interviewing, transcribing, analysis and literature searches. The volunteers have also been involved in a conference
presentation. Funding to support volunteer involvement was awarded by HEFCE.

Participants

**Methadone using clients**: Clients were invited to participate in the study by letter from the SP or by their drugs worker, and/or by a researcher at drop-in sessions held at the SP. Clients were given the choice to give an interview, either at the project or at a place of their choice, or of completing a questionnaire anonymously. The questionnaires were offered so that we could include the views of those who did not want to be interviewed.

In total we received 21 questionnaires, conducted 15 one-to-one semi-structured interviews, and one group interview with eight participants. It should be noted that some of the questionnaire respondents were also interviewed, but not all of those interviewed completed questionnaires, so there was some overlap between the two groups.

The interviews were audio-recorded, with participants' permissions, transcribed and checked against the original tapes for accuracy, and then returned to participants for consent. In total, consent was checked three times with each participant: before the interview took place; at the end of the interview when the consent form was signed; and after receiving a transcription of his or her interview.

The transcripts were divided between the paid researcher and two volunteers and were analysed for recurring themes. All three researchers then negotiated the final list of themes over a series of meetings. Questionnaire responses were included in negotiating the end themes and to flesh out themes at the writing up stage.

**Relapse prevention group**: Clients attending the relapse prevention group were invited by their session leader to attend an audio-recorded group interview at their usual meeting time after their six-week series of sessions had ended. Five clients were interviewed about their experience of being in the group, and about issues related to relapse. The same people were invited to a follow-up interview six weeks later. The SP sent out a reminder letter on our behalf and two participants attended one-to-one interviews at the project. The interview transcripts were thematically analysed and written up. All client participants were given a ten pound voucher and a five pound note in thanks for their participation.

**Drugs workers**: Semi-structured questionnaires were issued to drugs workers employed by the SP, asking about their views and experiences of undertaking their roles. These were used as background information for a volunteer researcher who conducted two in-depth interviews. Three one-to-one interviews with SP staff were audio-recorded with the participants' permission. They were then transcribed and thematically analysed.

The same questionnaires were issued to drugs workers at several drugs agencies throughout Bristol. 10 completed questionnaires were returned. As there was so few staff employed for this work at the SP we believed the study would benefit from extending our questions to drugs workers in similar agencies, and that the inclusion of workers from the wider area would provide greater anonymity for SP workers. Questionnaire responses from other agency...
workers were used to ‘thicken’ the final themes and quotes have been used in relevant sections.

We used semi-structured interviews because there were a number of key areas we wished to cover: however participants chose the order in which questions were dealt with, and which areas they discussed in most depth, as proposed by (25):

“(The) investigator has an idea of the area of interest and some questions to pursue. At the same time, there is a wish to try to enter, as far as is possible, the psychological and social world of the respondent” (p.12)

Semi-structured interviews offer opportunities for negotiation between participants and researchers who may have different views about the direction of the interview, and allow a degree of collaboration and co-operation by viewing the participant as the ‘expert’ on the topic under enquiry (25).

Qualitative methods seemed the most appropriate way to obtain valid information (26) and an in-depth understanding of the clients’ perspective on drug treatment (26). Bearing in mind our awareness that the views of service users in drugs settings are normally difficult to access because of their often chaotic lifestyles and their sense of marginalisation, we wanted to conduct the research in ways that ensured participants’ on-going engagement, and that addressed the ethical issues of power and inequality that are often overlooked in positivist approaches. In line with our own philosophies and those of the SP we hoped that participants might feel empowered and valued by being involved in the research.

Our intention was not to elicit standardised data for comparison with other individual's or groups (27) so we were not concerned with establishing the participant’s verifiable level of recovery, but rather with their understanding of their own drug use, what they saw as the causes, and their experiences of treatment. We were not seeking participants’ patterns of drug misuse but rather what Rodner calls their ‘drug talk’ (28). A person’s way of talking about their drug misuse cannot be separated from the societal discourses in which they are immersed and by listening we can gain valuable insight into the social meaning that they attribute to drugs and how that shapes their identity. This insight is essential in developing successful interventions (28).

Analysis

An inductive thematic analysis was carried out on the data by three researchers working on a given number of transcripts individually, and then together negotiating the final themes. Multiple analysts can benefit the work through the “contents of (coding) disagreements and the insights that discussions can provide to refine coding frames” (p.116 orig) (29): The analysis involved looking at each transcript separately, repeatedly reading and making notes about each response, a line or a paragraph at a time as appropriate. When each transcript had been re-read several times until no further insights were gained, commonalities and differences were noted between participants’ transcripts. These commonalities and differences were arranged into basic themes, and representative quotes for each theme were picked out from the
transcripts and ordered by similarity. Sub-themes were constructed from the quotes and a short description of each attempted. During the writing some of the themes were reordered as narrative descriptions allowed quotes to be seen in a new light.

‘Addiction’

In this report we use the term ‘addiction’ when referring to the discourse or popular understanding of the phenomenon of drug misuse. When representing the experiences of our participants we prefer instead to use ‘drug misuse’ (in line with the staff at the SP) or ‘problematic drug use’ as it has been suggested that the concept of addiction may no longer be helpful (30).

‘Addiction research literature suggests the concept of ‘addiction’ is indeed problematic, requires revision and often muddles social discourse, moral dilemmas, psychological states and pharmacology in an awkward manner.’ (p.8) (15, 27).

Historically, drug misuse was seen as a health problem and those presenting for help were referred to physicians, psychiatric wards or/and other clinics (31), (19). To this day the basis of the addiction concept is that a fixed set of behaviours and feelings are the result of biological processes produced by a drug, for example, withdrawal and craving are thought to be responses to particular drugs that are universal and unaffected by individual, cultural or situational variations, when in reality, behaviour is far more varied than these notions suggest (32).

Instead addiction should be considered a social, cultural and political construct rather than an intrinsic property of certain individuals or substances (33). The guiding model for treatment is therefore shifting from one of disease to addictive patterns of behaviour (34). We are interested in what Larkin and Griffiths refer to as ‘the process of addiction’ (35), the individual’s adjustment to, and habitual style of coping with, his or her environment (32). We understand drug misuse as a recurrent pattern of functional behaviour that leads to physical, psychological, social and other life problems (34), but as a pattern that can be modified with changing life and psychological circumstances (32).

Trauma

In areas such as Southmead many people encounter drugs routinely (36) and some may have parents, siblings or friends who are drug misusers. As outlined above in the Shaftoe (1) report, Southmead also has a high proportion of social services referrals and children on the child protection register. This led us to think about the concept of ‘trauma’ in a holistic and sociological sense, including the impact of poverty and marginalisation (37), as well as an outcome of physical, emotional, sexual abuse and neglect, as it can be difficult to distinguish between the impact of poverty, domestic violence and familial drug misuse (38).

What the report contains

The report addresses relevant up-to-date ‘grey’ and academic literature in the field and uses it to support discussions of the data we have gathered.

This document is split into three main sections. Firstly we discuss the findings from the
The second section looks at the experiences of clients who have attended the relapse prevention group. The themes gained from an initial group interview and two follow up interviews are discussed with a view to exploring the meaning of the group to clients.

The third section shows the findings from the data gathered from staff members to show how they approached their roles at the SP and what it was like to do their work.

The main findings of the three sections are finally brought together and recommendations made.

interviews with the methadone users who have been/are supported by the SP. The themes themselves are divided into four broad sections that address different stages of clients’ drug ‘careers’; the onset of drug use, the change from recreational to problematic use, the decision to give up drugs, and their experiences of treatment. Although the interviews did not aim to gather narratives, they nevertheless elicited a short life story from each participant when discussing their drug use, so we show the development of their drug ‘career’ as they saw it. We begin with Mark’s story which illustrates one man’s lived experience of the themes that are developed in later sections.
‘...he’d started when he was 11 when his father left home. When he was 13 his mum had by then taken in a partner and this partner used to beat him and his mother, so he attacked him one night with a baseball bat and was thrown out of the house, at 13. Nowhere to go, got into drugs and that’s one side. There’s another one who about 14 years ago was forced to watch his friends being systematically raped when he was between 10 and 14, youngsters, and he couldn’t stand that, just couldn’t handle that. There’s others who just started off using cannabis, bit of blow with their mates, no problem.’ (Mike Peirce, Chief Executive of SP).
METHADONE CLIENTS' THEMES

Mark's Story

Mark is a 39-year-old client of the SP. We are reporting his story here, using his own voice more fully because it illustrates vividly the lived experience of drug users in the local community and clearly links with the themes that have emerged from other data collected for this study. It tells of the ‘kind of life’ (39) that is lived by many of the people included in our study. Embedded within a person’s story we hear their feelings, thoughts and attitudes, and the richness of the narrative helps us understand how they understand themselves, their strategies for living and how they make theoretical sense of their lives.

Mark has given permission for his story to be used in this way and, although some details have been changed to preserve his anonymity, he is aware that the uniqueness of any story can make it recognisable to those who are intimately connected.

“I'm 39 years old and my choice of drug is heroin. I've been on it for nearly a decade now. I first started taking it through a relationship breakdown, where losing my children was something I couldn't handle. So it was a whole complete change of destiny for me. I went to the doctors for help, couldn't find anything, so finally I had to medicated myself.

Since then I've been trying to find a way of getting out of my life. I think finally I've found a way. And I'm working on that every day. Before I took drugs I was very outward going, very creative, very sporty. I have great pleasure in having children around me, and teaching children, but because of the last decade I've missed out on all that and I've found it hard to remem...to find out the person I used to be. Now that my memory is coming back, I look on this last decade as a learning process and I'm gonna act on what traumas I've bin through.

I put my drug using down to something that happened to me when I was 9 years old. I had a 7 year old brother who was killed on the Avenue, wearing his spacesuit. I watched it slowly kill my father: it separated my parents; and it had a real effect on the whole family. At the time I buried my head in the sand and tried to cover it but I found it come out later on in life, and mainly in the last decade where all my problems just come at me at once. So looking back, I think that was the first thing that made a direct change in my life. It caused a domino effect from there on.
For a few years I was happy - from the age of 18 till the age of 29 - when I was with my wife and my children. They were the happiest days of my life. Since then I haven't been a very happy chappie at all. But now, because of the project, I can see light at the end of the tunnel. I know now I'm finally going to break through it and come through. And hopefully put the negative things that happened to me into a positive way.

At the age of 13 I started dabbling in drugs, solvents, mainly evo-stik. I moved on then to taking magic mushrooms, trips, and things like that. Then it was on to amphetamines, cocaine and then I had a rest where I took nothing. I didn't even drink when I had my kids, and then I found myself back into drugs on the break up of the relationship, and that's when I turned to heroin. Which is the last one of a line of...poisonous chemicals.

It started on a school holiday, in Ross-on-Wye. We were on a venture project, staying in a college and some Evo-stik was found in a cupboard. Someone had already done it before, and introduced us to it. That was the first time I'd ever taken anything, then it just steamrollered and then, when I got old enough and wise enough, I stopped and I settled down. And then, because of that...that break up I turned back to 'em.

It was just that Evo-stick was available at the time.. Maybe it could have been anything, whatever would have bin there we would've been doing. There was no need to do it really, we were enjoying our holiday anyway, we were just kids...I don't know - curiosity...that...that was why I think did it.

I always said to myself that I would never ever touch heroin. But saying that, you never know what's around the corner. I never believed that I would ever take heroin but then I found myself...y'know.. Because I do stand against drugs, I always have done. Why I did the things I've done is beyond me; I still haven't figured that one out. I still remember when I said I would never touch heroin, yet I found myself taking it. But I used it as an emotional painkiller.

I didn't use it to get high. I used it to take away the emotional pain that I was feeling, which I found it a good thing for. Without heroin I think I may have committed suicide.
Findings - Mark’s Story

Not saying there’s any upsides to it, but in a sense it may have saved me. But then again it turns against you and then it works the opposite way, so - I don’t know if anyone else feels that way but that’s the way it felt for me.

At first I’d use heroin just weekends, with friends…then it become more often. I found I was drying mushrooms then so I could take them after the season was over. I sort…I enjoyed being out of reality, you know. Sometimes I’d find myself testing myself. I’d sniff glue on top of mushrooms just to see the effects - and if I could photograph the things that I saw and the things that I felt it would be great. But I can’t so I just got to do it all now from memory.

When I was married I had the feeling of settling down. I had a partner, I had responsibilities, I felt - well, its not just my life now, I’m sharing my life with someone else so why put misery into their life? And that was the reason why I stopped. And then having children then put…put a full stop on it for me. That was it then. Drugs? No! Know what I mean? I’ve got children. I’ve got responsibility. It shouldn’t be in their face.

The group of friends I had when I was married - those are the ones that I shut myself off from with the drugs. I didn’t associate them with the drugs. So when they see me now they still see me as the person I was when I knew them. So they’re the friends that I’m associating with again now.

They don’t judge me, um…so…and it helps, it helps. Because I think to get away from drugs you have to change your whole lifestyle, means you have to change your friends. If they’re still taking drugs you have to stay away from them. Because as Oscar Wilde said - temptation’s the only thing you can’t resist.

I was in a friends’ flat one night after I split up from my wife and lost contact with my kids and I was at my lowest and he said: ‘I’m not trying to get you on heroin or anything like that, but I can see the pain that you’re in.’ He said: ‘I can give you a small dose of this which would help you through the night and tomorrow you might feel a bit stronger.’

I had a few lines - it helped me, it made me feel better. The next day I still felt the same, so I medicated myself again. And that was that. I don’t blame him, he just felt so sorry for me, he
could see the pain I was in, he was just trying to help, you know. He did warn me of how quickly you can get addicted to it, which I already knew anyway, but I was in so much pain I felt like I had to do something. You know? And...

I had already been to the GP and told him, and he said basically you’ve got to stand up, dust yourself off and carry on with life, but (sighs)...for some people that may be easy, but depending on how you felt about your children, to me they were my world, and I'd lost 'em. If I'd had more help from my GP I don't think I’ve ended in the position I am now. Most definitely.

I became addicted to heroin about a fortnight after I first started using it. Smoking it takes a lot longer than injecting it. Injecting it you can be addicted within 2 days. I've known people smoking heroin for 6 months...go to prison, wait for turkey to happen and it didn’t happen. So, it does take a lot longer by smoking it for it to really...get in to your bones.

My life changed fairly quickly...so...well, I remember, I was in a flat and there was a hairdressers down below and the girls saying to me 'I've never seen someone go downhill so fast in all my life.' So it was a matter of a couple of months. I'd lost two stone in weight, I'd got that grey yellow colour in my face, the way I dressed changed, it was just the...the complete opposite to everything...I mean, it was the complete opposite of me. Like yin yang, it was the total...total, total change.

At first it was just...general use. But ...then I got clean for four months and all the emotions came back again, probably heavier than they did at first. Felt like I was reliving...Then I was into really heavy into use, if the conditions were right, if all the equipment was new. But I did prefer to smoke it. So, that was...between, '97 and '99 was when I was really, really into it heavily. I was probably, probably doing, oh, 2 or 3 grams a day - which is quite a lot, quite a lot. And...uh, this time before I got any treatment I'd weaned myself down, so...you know I said to myself, it's time to stop now, I'm too old for it. I'm getting a petty criminal career, which wasn't me anyway. I was always hard working and all the rest of it. And I thought I can't be doing this, my children are getting older and I didn't want to be an embarrassment to them. So...a lot of things made me think it's time for a change.
Findings - Mark’s Story

I saw my children but I'd rather - sometimes I'd think no, I'm on drugs, I don't want them seeing me on drugs, I don't want them seeing their father, dishevelled, in an unkempt way - I want them to remember me as...as the person they looked up to always tidily dressed and my daughter saying to me 'dad, you look nice.' But I'm getting - I've got contact with them again now, and it's helping me an awful lot.

My lifestyle's coming back to what it used to be. I'm tidy again now and...that's the way I want them to see me. I don't want them to have any bad memories of me...no. I mean, I was a good father...so...I won't put drugs anywhere near children. To me that's a no-no and that's the way it should be. We haven't got round to talking about that yet, but I think they still see I'm struggling, so they'll ask questions when the time is right, I know they will. I know they will.

I sought help from the project. I'd known Mike, the Manager, before; me and him go back quite a long time. They told me how they set it up and said: this is how we do it, are you willing to do it that way? I said: 'Any way, as long as I'm getting some sort of help.'

It was difficult at first, 'cos...the first thing you have to do is find someone you can trust. Soon as you find someone you can trust then you can open up. It took me a few counsellors before I found the one I could really open up to. 'Cos I've had a few scripts before and failed. But...I can open up with Monica for some reason...some...some other counsellors I couldn't.

But I open up to Monica, you know. And I find...I find her a great help. And I think that is the main factor, you trust someone, you tell them about your innermost feelings. It may embarrass you, by telling, because you're a man and you're talking to a woman. But I find it easier talking to women than I do to men anyway. I feel if I tell a man my emotions and what upsets me he's going to be laughing at me, thinking 'well, you know, you want to sort yourself out' but with a woman I think they're more compassionate, I find it easier to open up to them.

This time's different for me because I'm stronger, I've got a counsellor that I trust, ...'cos of my age, 'cos of my children...they're at an age where they understand, you know. When they were young it wasn't too bad because they didn't know what it was. But now they know what it was, I don't want them thinking 'because my dad does it, it's all right for us to do it.' I don't want to be
a bad influence. So there's a lot of factors that's making me stronger. I know this time I'm going to pull it together.

I've used other services the project offer: I've done a progress back to work, anything they suggests I...I'll have a look at. I've done all the relapse prevention groups. I'll have a look at anything to do with getting people away from drugs. And I'll tell them 'that's good, that'll work' or 'that won't work.' I've said to them, 'use me as your eyes, and your ears. I've seen it on the street.' Anything you want to know about what's happening out there.. I'll tell them. Without that they can't do their job properly. That's the way I like...it helps me to think that way.

The most useful part has been the relapse prevention. I think relapse prevention is...is...something that's needed. It's easy getting clean - it's staying clean that's the hard part. Relapse prevention.....we've tried a couple of things, canoeing, outward bound stuff. Because we've been on it so long we've forgotten the real world - there is a life, you know. You have to be reminded that there are good things out there. And the relapse prevention I think is um...a thing that should be in the top three of keeping someone clean and away from drugs again. Relapse prevention, yeah. Definitely, without a shadow of a doubt.

I've done a lot of outward bound stuff. I done operation Raleigh, operation Drake up in the Mendips...and I think that's great...reminds you what life's all about and how...and how your natural talents come out, and definitely, definitely outward bound stuff for relapse prevention, definitely, definitely works. Worked for me. And it's worked for my friends, and we're all, we've all been involved in drugs for a very long time, and we...um...know. We do know relapse prevention is the key.

Sometimes I've found that the red and yellow card business...isn't very useful. At first, it was yellow card, then if you've done summat wrong, within a week or so red card and then you were off. But now they've re-looked at it and they've changed to 4 weeks which is better. I didn't agree with it at first but now I agree with it.

It's...it bucks people up. Gives them ...a shove, if you know what I mean. Buck up - you're in this serious, there's serious people waiting on a list and you're messin' about. So...I didn't agree with
that at first but now they’ve re-looked at it and now, now I agree with it. But otherwise, I think
the regime, the way we can set it up is great. Great

What I think of my future, what I wanna do? Well, I’m thinking of going to…to college, and...
…put in what I’ve learnt - counselling, whatever, you know what I mean. I feel eight years is…is a
long time. It’s a long teaching process, if you like, so I won’t throw that back in, you know. I know
what it’s like…what happens out there. I’ve had a lot of traumas in my life. Losing a brother
Christmas day, watching it kill my father, and then my relationship break up and everything
that’s happened to me… there ain’t much in life that can be thrown at me that…I haven’t got
round, over or gone through. So…I’m thinking that I want to turn it into a positive note rather
than a negative one. I don’t want to be looking on it as just wasting…eight years of my life. I
wanna think, well, them eight years, you know - wasn’t a complete waste after all. If I helped one
kid - that’d make me happy.

My sister has always been a great support for me. Because she understands - she understood.
She understood that out of the whole family it was probably me that was hurt most by my
brother’s death, because it came back and hit me later on again in life. And, I was very, very
close to my younger brother. I had another brother but I was very close to my younger brother,
very, very, very close. And my sister knew this and had always known this and always stood by
me, and she gives me …unconditional love. You know, she’s there for me - you know - and I find
that I can talk to her, I’m always honest with her, and she’s been the foundation of me getting
through, you know? She’s always had faith in me, saying ‘one day, don’t worry, you’ll click.’ Always
had that faith in me. Without that I don’t think I’d be sat here now…to be quite honest with
you. Family support is very important when you’re going through something like this, very
important. If your family give up on you, then you give up yourself.

Families who give up on their kids, that’s wrong, totally wrong. That’s going to kick the kid out
into a squat and into the shooting…galleries. It’s gonna make his problem worse thinking that his
family’s given up on him…and that…he’s no good, he’s worthless, he shouldn’t be on the planet.
That’s the way it’s gonna make him feel. It’s called tough love, people use it as tough love
sometimes, sometimes it does work. It makes them realise that they don’t want to lose their
family, but I think family support is vital. It’s vital. You know - in some cases it works - it does.
But I think that in the majority of cases it’s wrong. You know…that kid, he didn’t put the drugs

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on the street...you know? It's not his fault they're there...you know? And they should try and get to the bottom...why? Its not that he's taking drugs, its WHY are you taking them. And that's what the families should do. But then some families look on it as a disgrace and, they outcast them. It's totally wrong. It's totally wrong.

There are lots of reasons people take drugs. There's always an emotional one - usually from childhood...abuse - relationship breakdown. They are your main factors. Recreational...use. You'll find that there....They'll decide they don't like the person its turning them into and they'll just guide away from it...but if that emotional problem's there and it cures the pain of that emotional problem, then they will stick with it. Because child abuse must be a terrible thing for a child - even at an adult age to still feel there was that physical abuse, sexual abuse. Emotional pain is the trigger for staying on it. Otherwise people who don't have any emotional pain will find their own way out of it. They'll find it's not for them, they don't like the lifestyle and they will find their way out.

It's like um...this guy from the prison, he once give me this little quote: a man walks down a street, falls into a hole. He thinks he's lost and that he's in this hole forever. He keeps searching, keeps looking around, finally he finds a way out. He jumps out of the hole. The same man, the next day, falls into the same hole. He knows there's a way out, takes him a long time to find it, finally he finds it and he jumps out in the end. Third day, same man walks down the same street, he falls into the hole, he knows there's a way out, jumps out of it straight away. Fourth day the man chooses another road to walk down.

So...I always keep that in my mind. Only simple little words but they work for me.

Well, I say there's lapse and there's relapse. Like, if summat bad happens to someone on the methadone programme, they'll lapse - take heroin once. Relapsing is going straight back to it completely. I...truly admit I have lapsed, the odd time - but I haven't relapsed. You know, there is a difference between lapsing and relapsing. I think there's a time limit for people really finding that they've got to get out of it - even the ones with emotional pain, there's a time limit when they think: well, this ain't helpin' me. All it's doing is switching that pain off for a while and as soon as I stop it's gonna come back. And they realise that they've got to talk it out - it's the
only way to get rid of it, is talk it out, you know. Or write it down -you've got to get rid of it that way or it's never going to go away.

The people that do get off it - from what I've seen - is that everything clicks and comes together like a jigsaw puzzle. They've found a new relationship, things like this. Someone...may find a girl that was sexually abused too so they got someone to talk to...to relate to...everything must click together. That jigsaw puzzle must click together. If one piece is missing, then they'll still keep going till they find that missing piece. Everything in their life must go together or they're still fragmented, you know.

I think more money should be put into drug rehabilitation. I think any money seized from drug raids - any property seized from drug raids - should be ploughed back into drug rehabilitation. It'd cost the government less, and it'd be self-funding, if you like. You know? Whether, whether the Home Secretary would listen to anything like that I don't know - but that's the way I feel.

I'd like to go round schools and stand on stage and say 'listen kids - this is how it is. This is what's happened to me, this is what could happen to you. Nobody is proud of you when you take drugs, especially your family.' So - I'd like to tell 'em my story and a few other lads there - and then we'd lighten it up with a bit of music. You know, so they don't go away feeling gloom and doom. But I think that's the way we teach 'em. Action is better than reaction. That's the way I believe. Children will go for drugs 'cos it's curiosity. But if they know the effects of the drugs there's no need for them to try.

It is only short term. It's the same as prescribed drugs - valium, diazepam - they're only for short term. After that the body gets used to 'em and they don't work, and you become addicted to summat you're not even feeling. That's what we must get over to them. It's not going to enhance your creativeness or your sport forever. It will destroy you in the end. And we got to get this over. We've got to pick the right age group, an' I think first years in senior school would be the right time to pick on. That's the year when they're knocking around with older people. There's older people in their lives, who are going to introduce it to them. That's...that's the age group you pick on...an put it in to 'em as you would say, the fear of God. Put it into 'em that drugs are a no-no.
THE ONSET OF DRUG USE

Research has indicated that personal and social factors contribute to the onset of drug use. The effects of family disruption, belonging to a dysfunctional family, early trauma, delinquency, educational difficulties and adolescent personality and conduct disorders have been suggested as risk factors. Socio-economic deprivation, poor environment, repeated adverse life events, peer drug use, relationship problems, parental influences, unemployment, and lack of social opportunities are also thought to play a part (40), (41), (42), (43), (36).

Although the literature indicates risk factors and influences it does not provide an understanding of the context of drug misuse and how an individual first comes into contact with drugs: how they were obtained; or how the person experienced drug use. Drugs are usually used for a reason, whether for fun, to self-medicate against emotional or physical pain, or just to feel different (43). So in this section we discuss what participants told us about their first experiences of using drugs and the contexts and reasons surrounding their introduction to the drug whose use eventually became problematic.

Social introduction to drugs

Individuals learn about drug use informally in a variety of ways: through observing others using drugs; through socio-cultural influences such as the media, song lyrics, social rituals (44); and popular myths (45). In deprived areas, such as Southmead, high unemployment, local ‘economies’ of petty crime and the ‘melting pot effect’ (46) of problem housing estates mean that young people encounter drugs routinely (36).

Drug use is a typically social activity and hardly ever starts as a solo pursuit (47). The most commonly reported reason for the onset of drug use by our participants was as a group leisure activity with friends, family and partners, beginning with cannabis, solvents or alcohol before moving on to harder drugs such as heroin or crack cocaine which were introduced at a later stage (also reported by (45). However, the use of ‘soft’ drugs like marijuana does not always lead to the use of increasingly ‘harder’ drugs (48).

Marijuana is common as a first use drug and because it is usually widespread among peers it is perceived as not particularly harmful (49). Drug use can be part of the local repertoire of available leisure and lifestyle choices (50); (51); (52). First use was usually something that ‘just happened’ rather than a planned event (53).

A Relational Activity

Our participants reported that substances were commonly obtained from peers or a peer’s older sibling, and their use was just ‘something that they did’ as a group. Some participants started using solvents or cannabis with friends and for Helena the move to heroin and crack was a gradual one prompted by her peer group: ‘Yeah, one day like we’d be round a friend’s house and we were all smoking dope and the next we were all smoking crack, so it was like from one day to… it all just changed…’ Don reported a more direct approach: ‘a few friends were doing it (heroin) in school and sort of said ‘oh you ought to try this’ and everybody started doing it.’
Findings - Methadone Clients’ Themes

In contrast with the findings outlined above (see (45)) some participants’ first experiences of drugs began with heroin. Neil rejoined a group of friends after splitting up with his girlfriend. During his absence from the group they had taken up using heroin and he felt a pressure to join in if he wanted to be part of the group again: ‘...when I started going around with my friends after I split up with my girlfriend they were all into heroin and I tried.’

People tend to select friends who are similar to themselves in certain ways (54), so it follows that those with an inclination towards substance use will build friendships that encourage rather than discourage that (55). In this respect, a group’s characteristics may be thought of as reflecting the interests and identity of the individuals as opposed to the other way around (45).

The experiences of poverty, deprivation, family disruption, early trauma and abuse may lead people to feel ‘different’ and unable to identify with others whose lives seem unproblematic. Adolescents in deprived areas experienced low self-esteem, passivity, a negative outlook on life and a history of dependent relationships (56). Whereas young people from stable backgrounds may seek reward in conventional activities (such as sports, the arts or the Church), marginalized individuals may find their rewards in drug subcultures, where they can spend their time with people they perceive to be like themselves, among whom they can develop new shared identities and lifestyles, and a sense of being understood and belonging (57).

‘Here [in learning about drugs through friends], there is great store placed on observation, conversation and the role of drugs stories - tales told and retold among young people”(p. 168) (52),

The illicit nature of recreational drug use further bonds the group. ‘Getting out of it’ is a shared secret between members, hidden from parents (58). Secret activities are shared in the group through the re-telling of their experiences, strengthening a sense of group membership and re-inforcing a sense of distance and difference from other friendship and/or family groups.

As well as the influence of the peer group two of the three female participants spoke of being influenced by their drug-using partner. In general, women are more likely to attribute their first use to social reasons (59) and as (60) points out:

‘Studies have found women more likely than men to use because a spouse was using, to live with a spouse or common-law partner during the year prior to first heroin use, to have a spouse who was an addict and who began using heroin before they did, and to be introduced to heroin by an addicted sex partner.’ (p.23)

Donna told us she changed her opinions about drugs when her partner of several years started using: ‘I started using drugs when I was 17, um, never used to touch drugs, at all, dead against it, then um, the boyfriend, I was with started using.’ Donna had been with her partner since their early teens and he had begun using drugs at 16. Donna found out almost two years later, aged 17, when he
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asked her to buy, and use crack with him. She
told us: ‘I trusted him that I wouldn’t get
addicted.’ When she became addicted to crack
they both fell into the addict lifestyle: ‘…with
both using, - just dependent on each other.’

When a woman is in a relationship with
someone who develops a drug problem,

‘the woman’s initiation into addiction
takes the form of immersion into the
world of her man.’(p.23) (60), as
quoted in (59);

Kirsty was also introduced to drugs by her
partner: ‘I was only 14 at the time, he was 29...
I kind of looked up to him and done it (heroin)
with him the first time.’

Romantic involvement with a heroin-using
male may appeal to females who fear
rejection. By entering into a relationship, and
eventually a shared addiction, they make
themselves indispensable to their partner by
providing support for them and their drug use
when others are less keen (59).

Several participants had older siblings who had
been drug users, a fact that has implications
for the way that they understood drug use and
familial reaction to their own using. For
example, older siblings may act as ‘influential
friends’ (61) who legitimise deviant behaviours
and potentially create curiosity or
competitiveness among younger siblings (62).
If younger siblings associate with drug using
peers there is also a greatly increased chance
that they will use drugs (63). Parents coping
with one child’s drug use may be less available
to monitor and supervise their other childrens’
activities and friends. Their concern with one

son or daughter might deprive their other
children of the attention they need (62).

Age at onset of drug use

The meanings associated with drug use can
only be understood within culturally and
socially specific contexts (43). During
adolescence and teenage years the need for
acceptance and membership of peer groups
makes it likely that young people will join in
with drug use as a way of conforming to
chosen groups and relationships (47).

Nick told us: ‘… there’s always been dealers in
Southmead, a lot of them were around about
my age’  Obtaining drugs from trusted people
of a similar age, does not reflect the myth of
the older pusher hanging around the school
gates with the intent of creating an addiction
(12). It is understandable that dealers might
supply friends and family members when
taking into account that dealing is one of the
few readily available ways of making enough
money to escape poverty in areas such as
Southmead (64).

Media myths about the effects and contexts of
drug use (sometimes re-inforced by drugs
awareness and education programmes) might
distract young people from learning about the
actual risks involved.

Harris (65) raises a serious challenge to
popular thinking when he states:

‘The fact that the majority of
people take drugs because they
are fun, help them bond through
shared experiences and provide
social ceremonies is a stark
reality which is wholly lost in
drug prevention messages and betrays the moralistic bias of adults.' (p.65)

Young people might minimise or dismiss warnings that focus only on negative effects when their personal experiences of drug use have been positive. They may believe that providing they are sensible and careful they can avoid harm (58).

‘Normal’ early teenage experimentation and curiosity

In line with the quote above our participants told us that they viewed drug use as part of normal teenage behaviour and there was an expectation that experimentation with different drugs was a universal phenomenon amongst people of that age. Michael said about substance use, including cigarette and alcohol use: ‘it’s the first thing that my whole peer group did and just about every peer group on the planet I think.’ He made reference to the effect of his community and environment on his curiosity: ‘it’s just seeing these things going on about me, just led on to curiosity, also the peer group I was with were all kind of right into experimenting as well.’

Many participants had experimented with a range of illicit substances, which was explained as an interest in testing boundaries and trying new experiences. Michael saw experimentation as part of youthful rebellion: ‘I’ve tried absolutely every drug there is, because of the curiosity to see what each one did. And adults always tell you that everything’s bad anyway at that age, so that’s basically it, its curiosity.’

At this stage, their experimentation with different drugs was still part of a social or leisure activity. The move towards problematic use did not occur until later in their stories. This is covered in the following section.

Curiosity can be explained as part of adolescent identity exploration (55). Most adolescents wish to have a wide range of experiences before settling into adult life: trying out different drugs may be part of that exploration. While it may be common for teenagers to experiment with cigarettes, alcohol and soft drugs out of curiosity it is less common for them to be exposed to heroin and crack. Of the regular drug users surveyed between the ages of 11 and 16, marijuana was most widely used (74.6%) with opiates or cocaine used by only 5.7% (66). The prevalence of heroin use in Southmead may not only mean that it is more available, but that its use is seen as acceptable for young people in the area.

Trauma and life disruption

Several studies have highlighted the role of family instability (67) early isolation, loss or separation, rejection, abuse and having an unpredictable home life as marking the onset of problematic drug use (33). The literature on experiences of childhood victimization indicates that there is increased risk for the development of depression, self-esteem problems, anxiety, sense of powerlessness, and social isolation in later life. This damage to a person’s sense of self, can lead to impaired social skills and an inability to trust others. It is therefore understandable that many victims may turn to alcohol or drugs in an attempt to cope with these effects (68), (69).
Some of our participants recognised that drugs had been their way of coping with historic or current traumatic events, life disruptions or emotional problems, such as death of a sibling or parent, physical/sexual abuse and adult loss through divorce or separation.

Nick identified the death of his father as a changing point in his life: ‘I started very young because my dad died when I was 11 and since then, I kicked off.’

John experienced an accumulation of negative life events that created low self-worth: ‘Not trying to make excuses, but just all those kind of instances you know compound somehow or other. I had no work, I’d had a job, and that had come to an end, ...developed quite a sense of worthlessness. Lack of self-esteem. Lot of things happening at the same time then. I’d had a girlfriend, that relationship broke down and um....’

Michael also told us that a series of events left him unable to cope: ‘...had various incidences in that period which kind of just sent me off the rails basically.’

Other researchers have found that their participants also reported experiencing personal crises in their lives that threatened their sense of self and identity (70) at a time when their search for identity was at its most intense (71). Traumatic life experiences can leave a person feeling isolated, and marginalized individuals may find reward and a sense of connection within drug subcultures, where they can spend their time with people they perceive to be like themselves, among whom they can develop new shared identities and lifestyles, and a sense of being understood (57).

However, some participants actively rejected the idea that their drug use was the result of a trauma or disruption. One group interview participant told us:

‘That’s one of the things that done my head in about drug rehab, they tried telling me...that I’d had some reason why I became a heroin addict. Something bad, but I haven’t. I didn’t have no reason why I become a heroin addict.’

Prevalent discourses around the causes of drug misuse (such as disrupted childhoods or the disease model of twelve step programmes) may not fit with clients’ experiences and may create expectations for clients to adopt beliefs that underpin treatment approaches (33). In other cases trauma histories may not be recognized, leading to treatment needs being unmet (37). If underlying issues that have led to drug misuse are not acknowledged or addressed during treatment, relapse might occur (69). By creating a safe space into which clients can tell their story at their own pace, and in their own way, they can be helped to release past trauma and experience healing and transformation (72); (73).

**Covering difficult emotions**

Another reason for using drugs was identified as a need to deal with difficult emotions. In some cases this was linked to trauma or disruption in their lives as discussed above, but in other cases it was linked with the presence of untreated psychological conditions, or as a
way to cope with, or escape from, their day-to-day lives. As Phil told us:

'I find that near enough everybody I knew used it in the past for totally different reasons. It's all to do with head problems mainly too much pressure an' too much depression an' hard to cope just a way just a way of gettin’ away from it for a while for a couple of hours."

As well as generally feeling unable to cope some participants used drugs to deal with psychological distress. Charlie told us: ‘The depression, just life alone you know, can drive you to it.’ Some of these participants told us that they had tried seeking help from their doctor and, when they did not receive the help they needed, turned to illegal drugs as a way of ‘medicating’ emotional pain, suggesting a belief that illegal substances effectively help cope with distress. One participant mentioned that they turned to heroin in a similar way that other people turn to alcohol.

The use of the term ‘self-medicate’ is widely used in substance misuse literature when drugs are used to regulate moods (74) or as a defense against unbearable distress (75). The fact that these participants had sought and been denied help from their local health services reflects a common problem where drug misusers have difficulties gaining the same kind of help offered to non-users in similar situations (76).

**Summary**

Although there seems to be no single identifiable reason why participants began using drugs two main themes emerged in the interviews: those who took drugs simply because they were available and a socially sanctioned pastime, and those who used drugs to escape from emotional and psychological distress created by current or historic trauma, which included the impact of poverty and marginalisation (37), as well as the more obvious trauma of childhood physical, emotional and sexual abuse (77, 78). All of this potentially creates distressing emotions and a sense of disconnection from ‘normal’ society. Some people used drug use to make everyday life bearable.

There is a history of drug problems in Southmead and some individuals growing up in the area are exposed to drug use routinely, having family or friends who are drug users. There was an expectation that recreational drug use was a normal part of teenage life, and an expression of curiosity. The fact that trusted friends or partners used and introduced participants to drugs legitimised their use. The bonding effect on peer groups fostered by engaging in illicit activities helped to maintain drug-using friendships and encouraged further use.

These two groups are certainly not mutually exclusive. The majority of those who started using drugs to cope with trauma or life disruptions also received their first ‘fix’ from friends. They therefore experienced similar social, community and lifestyle issues as those who used drugs as a social and leisure activity.
BEING A DRUG MISUSER

Participants were asked about their experiences of living as a drug misuser. Most accounts of drug use focus on frequency or amount of drugs used (58), whereas we were interested in the lived experiences from the drug user’s own perspective.

Discourses of addiction

GPs typically see two types of drug user: those who use drugs as a social and pleasure seeking activity, and those who use drugs to cope with negative life experiences or emotional states (79). As previously discussed, our participants also differentiated between the two: seeing the latter as the main factor that leads to ‘addiction’, even after years of recreational use. Michael graphically illustrated this point that was also made by made by others:

‘you can use heroin for years and years without having a problem, that's the thing. It's just that, if you lose control you know, or if you have a depression or a bad time in your life, then it can really get you, and once it's under your skin, once you've got a habit, that's the end of the world... Just like people turn to drink, it's exactly the same thing.’

Participants recognized that drug use became problematic when the motives for using changed, rather than when the amount used increased. The ‘addiction’ was seen to ‘take hold’ when they were using drugs to alleviate negative emotions (33), depicting the individual as a ‘victim’ of drugs with no free will against the effects (26). Alternatively the ‘individual identity discourse’ (80) assumes that a person is in control of their situation and drug using behaviour, and places responsibility on the individual for self-control (81).

Whilst describing the change in the function of their drug use, participants used language that seemed to indicate that they viewed the drugs as having power over them: they talked of drugs ‘creeping up’ and ‘taking hold’ when they were vulnerable. Michael described heroin as something that ‘got its claws into me.’ Don described addiction to heroin as a disease that ‘just sweeps over you, and gets a grip on you... its just so powerful, this disease...’

Some participants used action-related language that also indicated that being addicted created a sense of being impacted by external forces: using metaphors like ‘a domino effect’, ‘steamrollered’ and ‘sucked’, depicting drug users as being at the mercy of forces beyond their control (26). Donna said: ‘It's just a downward spiral all the time; it's hard to pull yourself away from it.’

These views may be reinforced by popular beliefs that certain substances lead to a series of universal behaviours, and that addiction is so powerful it cannot be overruled (32). Some researchers interpret these beliefs as a means by which drug users’ can maintain a positive sense of themselves by devolving responsibility for their drug misuse and problematic behaviours onto the drug (15). If the individual considers that their free will is taken away by the powerful pull of addiction (as in the disease discourse) then it may be easier for them to maintain that they are essentially a ‘good’ person who has been led to do ‘bad’ things (82) rather than accept that
drug misuse is related to weakness of personality or a moral failing (see the discussion of the stigma later in this section). Recreational drug users themselves have been reported to view drug-related problems as located within the personality of the drug user, thus contributing to the labelling of drug misusers as ‘deviant’ (45).

**Physical addiction**

Several participants referred to heroin addiction as a physical illness, whilst others saw it as a way of staying well (avoiding withdrawal symptoms). Michael told us: ‘... once you've got an addiction, a proper physical addiction... it literally keeps you healthy, so you're not ill, that's all it does. It stops you from being ill but it doesn't resolve those... problems that you're running away from…’

The disease concept was also raised in a group interview, with one group member saying: ‘I totally agree that it's a disease. People take heart attacks seriously and, uh, strokes and all that but they don't take drug addiction seriously…’

Donna commented on the differing qualities of addiction to crack cocaine and heroin: ‘crack’s mentally…, it's in your head. You either want it or you don't... with heroin you got to have that, your body needs it.’

The term ‘addiction’ itself suggests a powerful psycho-biological condition requiring specialist medical treatment (43). The concept of addiction as an illness may be comforting for some people during recovery, alleviating them of a sense of responsibility and thus allowing them to build or maintain a more positive view of themselves. However, it may also lead to a sense of loss of agency and powerlessness, which although seen as necessary as part of recovery within AA circles, (acknowledging that they are powerless against this drug) it might also discourage people from using alternative ways of transforming their lives. The disease concept can also act as a self-fulfilling prophecy where the misuser is forced to adopt addiction styles in order to survive within the society (83).

**Shifting to Problematic drug use**

Participants talked of their shift into problematic drug use as impacting on their physical appearance, their sense of identity and their lifestyle. In effect, they became a ‘different person’, living a different life.

**Physical Change**

Some participants identified a noticeable physical change in themselves: loss of weight, dental problems and a loss of interest in their appearance and dress. Charlie describes the changes he and other people noticed in him: “I was getting skinny, my teeth all went rotten... and people were saying, god you don't half look a state, you're wasting away and your cheeks going like that. It was real bad part of the time....I mean I was skinny, arms shaking, nervous all the time. A right state seriously. I lost all my teeth at the top through heroin.”

Change of appearance has an effect on the person’s embodied sense of self and identity, drawing attention to their state of dependence, and leaving them more open to the discrimination that stigma attached to drug misuse invites. Some participants who were able to maintain their appearance used that fact as a means to differentiate themselves.
from other addicts. Helena told us: ‘Yeah, I went downhill but I always kept my appearance, always looked tidy and things like that.’

**Change of lifestyle**

Participants told us how their everyday routine changed as their drug use escalated. The need to obtain drugs became the focus of their days, shaping their lives and their relationships. Don told us: ‘...a lot of my life’s been filled up with...going out earning money for drugs.’ Several participants talked about stealing and shoplifting in terms of ‘earning money’. The need to satisfy the craving for heroin was also seen to reduce a person’s expectations that there might be any other ways of living.

Escalating drug use also had an effect on relationships. As drug use increased, participants spend more and more time with other drug users and less time with family and non-using friends (84). Participants indicated that there were several reasons for this: family and old friends did not fit with their new lifestyle but reminded them of situations and emotions they were trying to escape; or shame about their drug misusing lifestyle can lead some people to stay away from family: Don said: ‘I love my sisters dearly but I don’t like them seeing me in this state.’ And Donna told us: ‘I didn’t hardly see them (my children)...I didn’t hardly keep in contact. I’ve let them down a lot so I just didn’t.’

These kinds of changes in relationship are common among drug users (85) and may isolate them from relationships that could provide necessary support (33).

When those relationships were lost, new relationships based around drug use were formed. Drug users’ social groups shift to adapt to the levels of using or to groups using their particular drug of choice (86)

‘Drug subcultures differ regarding to the extent to which they represent an occasional leisure activity versus a lifestyle, an amusement versus a worldview, and an interest occasionally shared with others versus a group affiliation demanding limited association with non-members.’ (45; p219)

These friendships provide a new social identity and membership of a subculture with its own language, lifestyle and out-groups (86). These new social norms further isolate the individual from non-users and ‘normal’ life.

Even though drug users spend most of their time with other users, they are rarely seen as friends rather they are viewed as companions in the pursuit of drugs (67) and are sometimes regarded with distaste (87) and seen as a barrier to changing lifestyles.

**Change of self/identity**

Participants reported a split between their view of themselves as drug users and how they were before, not just relating to their relationships and behaviours, but also their personal characteristics and beliefs. Recovering ‘addicts’ frequently make a distinction between the person that addiction has made them and the person they believed themselves to be at heart (87).
Phil remarked upon the change in his sense of agency or power: ‘it takes away your will power, your will power to say no, it destroys it. I used to be quite a strong willed person but not any more.’

The quote directly above illustrate that identity is continually being negotiated and reconstructed. Participants may go through frequent self-analysis considering what it means to be an ‘addict’ resulting in a sense of uncertainty about how to reconcile their drug using and non-using selves (33).

The concept of identity may have an important place in our understanding of drug use and recovery (34): successful recovery may require the user to revert to a previous identity, modify their current identity or develop a new identity (88).

Stigma around drug misuse

Our participants were acutely aware of the negative public perceptions of drug misusers. In particular they were conscious of the moral judgements made about ‘drug addicts’, and that addiction is seen as a moral failure. The war on drugs policies of the 1980s have been pinpointed as having helped to criminalize and stigmatise drug users (89). Michael said: ‘It’s not like you’re an evil person simply because you’ve screwed up in your life. You can make other mistakes in life, and people don’t judge you for them, but if you’ve got a heroin habit people judge you for it …there’s a particular stigma to being a heroin user.’

“one is no longer a ‘user of heroin’ (a particular kind of ‘addict’) but simply an ‘addict’ (a particular kind of person - identified by a particular kind of relationship with - potentially - many kinds of behaviours)” (33): p301.

Knowledge about substance misuse is never value free, but reflects moral opinions about the appropriate or inappropriate use of different substances (15). When a person judges himself negatively and is judged negatively by others, he may embrace the company of ‘deviant’ people and reject ‘normality’ as a means of lessening the discomfort of being reminded of the distance between their own lifestyle and that of ‘normal’ society (90, 91).

Participants also acknowledged the stereotype of the ‘typical addict’ and they were keen to distance themselves from this identification. Their denial of themselves as being ‘a typical street addict’ allowed them to maintain some sense of self worth through recognising that there were still things that they believed to be morally wrong. If a positive identity is not easily attainable then criticising the negative qualities of others may provide a measure of self-worth (81). For example, Don maintained self respect by stating the limitations to the ways he funded his habit: ‘I’ve never…robbed any old people; I’ve always supplied my habit by, through shoplifting.’ Helena also distanced herself from some of the negative stereotypes around drug misuse: ‘I don’t use needles, things like that, and I’m not a chaotic drug user, running around to get drugs.’

Stigma related to drug misuse was also thought to be a barrier to making and maintaining relationships with non-users. Michael pointed out: ‘The way that people talk to you, it’s almost like…people talk to someone from abroad for instance, you know, in a kind
of funny patronising way because maybe they don’t understand English for instance…treating you like you’re kind of basically sub-human, abnormal you know. You do get that a lot.’

During a group interview another participant said: ‘Yeah, that’s the hardest thing because when you’re off of it [heroin] finding people…who you can actually get on with…. When you’ve been on it so long like, you talk to someone who ain’t on it and you think, nah that just ain’t my thing, I just can’t co-operate with them.’

Other researchers have reported that their participants felt that their ‘addict’ identity caused problems in interactions with non-users (33). Another barrier to building good relationships can be erected by drug misusers’ suspicion of other peoples’ motives for befriending them, and their expectations of being mistreated in reaction to having been ‘ripped off’ by other users in the past.

Reflection on own drug use

Narratives of recovery often differentiate between several images of ‘self’: whom the person was before using drugs; the person they have become since using drugs; and the person they aspire to be in the future (87). As participants related their stories for this study they reflected upon past, present and future, in their attempts to create meaning out of their lives.

Narrative psychology believes that people make meaning of their lives by reflexively ordering it as a life story (92); (85); (93); (94). A coherent self-narrative is particularly important during change as it helps maintain a sense of continuity and allow for visions of the future (85). Some participants indicated that the process of narratively ordering their lives raised painful questions about how their lives might have been shaped by events that occurred: On reflecting upon the sexual abuse he suffered as a child Don mused: ‘I’ve always wondered, would I have turned out different if that hadn’t happened.’

When talking about past problematic drug use several participants reflected on the gains they had experienced. Mark reflected: ‘I think after this last decade I’m looking on it as a learning process…I don’t want to be looking on it as just wasting…eight years of my life. I wanna think, well, them eight years, you know - wasn’t a complete waste after all.’

When creating a life story it is not simply a case of arranging the facts but rather creating a socially and personally functional account (95). Mark’s re-appraisal of what he has learned from drug use may be a way of establishing a positive outlook: learning about himself and the world that will help him build a future self, more rewarding than his past or current self. Such a positive orientation towards the future is viewed as helpful in successful behaviour change (33). However, other theorists believe that an important part of developing a non-using identity involves interpreting parts of a drug-using lifestyle in a negative light (87), for example not focusing on the euphoriant effects and shared experiences drug users experience while using. Our participants seemed to be saying that although they evaluated the experience of ‘addiction’ as negative, the learning and life experience they have gained from coming through it has enhanced their sense of self and identity. Another explanation for the positive appraisal of their problematic drug use can be a result of
positive affirmations received from drug workers that shape an individual’s narrative of recovery (87).

**Giving back**

As well as learning from their past drug use, participants were also keen to put what they had learned to good use. The desire to contribute both to the SP and to society in general was evident.

Charlie’s words indicate his need to reciprocate by: *[giving] something back for what they’ve helped me; I would like to help someone else.* Charlie is referring here to a particular strength of SP - their ethos of involving service users in the life of the project, perhaps through arts projects, committee membership, and indeed, through this research.

Rather than being *only* ‘a service user’ clients were keen to be active members of the SP, contributing something in exchange for the help they have received. This suggests that the participants were starting to identify with the project and build relationships that go beyond attending for counselling or a means of accessing a methadone prescription. The project had become part of their identity; they were starting to identify more with a ‘drug-recovery’ than with a ‘drug-using’ subculture. The practicalities of feeling affiliated with the project also means that they are less exposed to non-recovering users and spend more time in an environment which positively rewards recovery by helping to reinforce a non-drug using identity.

**Summary**

The experience of problematic drug use was one of change for our participants: change from who they were before, and change during and after their addiction (87). Their move from recreational use to ‘addiction’ was thought to occur during a difficult period when their drug of choice took them over, leading to a physical addiction that required constant ‘medication’ to avoid unpleasant withdrawal states. Once the ‘addiction/illness’ had taken hold there was a shift from ‘the person they were before’ and the development of a new addict identity and lifestyle. New relationships were made and old relationships neglected: a new ‘addict self’ was formed with different beliefs and moralities and sometimes an altered physical appearance. The resistance to such changes was a source of pride for some participants who stated that they ‘weren’t like other addicts’. This helped maintain a positive sense of self in light of the stigma attached to drug users that blighted their attempts to form non-drug using relationships.

The adoption of an ‘addict’ identity began the journey to a renegotiation of their life narrative, possibly starting from the need to cope with the traumatic events that marked their move from recreational to problematic drug use. The adoption of a drug user identity may lessen a sense of alienation created by trauma through creating new affiliations and reducing the feelings of difference experienced in ‘normal society’.

The groundwork for a new identity as ‘recovering drug user’, laid down by their connection with the SP, was built upon by a desire to give something back and become
involved. This shift in identification contributes to a positive appraisal of their experiences of drug use and allows for a positive future outlook. Participants’ life narratives were continuously being negotiated in spite of some individuals remaining uncertain about the place of key events and turning in their stories. This indicates the importance of counsellor involvement to help clients establish a coherent and functional story that provides positive orientation for the future (85).

THE DECISION TO CHANGE

The ‘client’ participants in this study were people who had already made the decision to give up using drugs. Whilst some clients attend the SP as part of bail conditions, none of the participants we interviewed gave this reason for being there. Their stories about why they came to the project were embedded within other stories about specific turning points that had helped them decide to give up drugs, thus reflecting findings in several other studies (96); (97); (98).

Influence of roles/relationships

For some of the participants with children their family responsibilities were a key factor in seeking treatment, and a motivation for staying drug free. For some users the decision to stop is made when their ‘addict’ identity conflicts with other valued identities that are unrelated to drug use (88), or when they accept an adult role in life (99), e.g. those of a parent, partner or employee.

For Helena, the decision to stop using drugs came when she discovered that she was pregnant: ‘This time it’s because I knew that I was pregnant and just knew that I had to sort myself out for my baby.’ The birth of a child is an often-cited reason for wanting to stop using drugs, for both sexes (100). For others, like Nick, the realisation that they had missed previous chances at being parents because of their drug misuse triggered the decision to abstain: ‘It’s only been since my little boy was born - the last one - that I thought this is my last chance now at fatherhood.’

Having children may be a reason for some people to quit drug misuse, but loss of custody
doesn’t necessarily strengthen the desire to get clean. As Donna explained: ‘your kids go and - to get your kids back - you think that it’ll stop you but it don’t - it just makes it worse. If you haven’t got your kids then you’ve got nothing.’ Rather than acting as an incentive to stop using drugs, the loss of her children removed one of the anchors of ‘normal’ life for Donna, leaving her with less reason to abstain from drug use.

Having ‘a stake in everyday life’ can help many users control their drug use or quit completely (101). Without a reminder of normality the misuser may retreat further into the drugs subculture thus losing one of the prompts that helps them evaluate the impact of their lifestyle on those close to them, or to face up to the person they have become (100).

**Time for change**

Participants sometimes made a decision to stop using drugs in response to an accumulation of factors. Life had become too problematic for them to continue without seeking help. As one participant in the group interview put it: ‘It was either jail, death or this [attending the SP], you know, like ‘rock bottom.’ For many users the decision to change comes when they have reached a point in their life beyond which they are not willing to go (102); (103); (104).

Donna recalled how desperate her life had been before she decided to quit drugs: ‘Using every night, not sleeping, fitting. I’ve been in hospital, OD’d [overdosed], I’ve been raped, I’ve been, you know, working the street.’

Women are more likely to be involved in the high-risk aspects of drug sub-cultures (e.g. sex work, drug mules), with resulting health, financial and legal implications (105).

The decision to change frequently stems from this kind of distress about the drug taking lifestyle and the methods used to fund the habit (100). The lifestyle becomes unacceptable to users themselves and significant others, and they become concerned with repairing their ‘spoiled’ or stigmatised identity (106).

**Relapse**

All of our participants were either currently not using drugs, on methadone, or on a waiting list for a methadone prescription. Despite the obstacles and setbacks mentioned above, with most experiencing at least one lapse, the participants were still eager to give up using drugs.

For many users giving up drugs isn’t a one-off decision: the majority require several attempts (100) as one group interview participant pointed out: ‘I’ve hit quite a lot of rock bottoms (laughs), I’ve been trying to get off it for ages, but never seem to do it. The longest I’ve ever stayed clean is a year and then relapsed, ended up back here.’

For some, even when on methadone, the physical craving for heroin was too strong to resist. Helena described the relentlessness of the craving: ‘Some days I get a craving, and you deal with that and the next day it’s there again, and the next day, and it goes on for days - and then I end up using.’

For others, adjusting to life without heroin was the most difficult problem. Overcoming addictive behaviours may involve profound changes in a person’s self-concept, values,
and a re-orientation of life, social status and relationships with other people (107). One group interview participant described this problem: ‘It’s easy just to try and stop taking drugs but then it’s trying to live without the drugs, and dealing with things.’ Donna also made this point: ‘You’ve got to learn all life skills again and everything, all your emotions and how to deal with things. That’s what’s hard.’

These changes may be difficult to manage in the face of opposing forces in their social world (108). For example, while supportive relationships, stable environments and rewarding employment may help changing addictive behaviours (102), factors such as bad housing, poverty, limited occupational opportunities, poor relationships and dissatisfaction with one’s own life may hinder any attempt at change (109). This suggests that the need for support at all stages of recovery is vital, not only during initial detoxification but also when trying to maintain a drug free lifestyle.

Summary

For our participants, conflict with their ‘old self’ or roles associated with a non-using lifestyle appeared to be the key factors in the decision to change their problematic drug use.

The desire to perform the role of a parent and partner was discussed by several participants. They recognised that their roles of drug user and parent were not compatible. When their drug use had an impact on someone very close to them it was no longer acceptable.

For others, their level of drug use had prompted a change in their lifestyle and identity and they had reached a point where they could go no further. This was usually prompted by a series of events that the participants felt were unacceptable, often involving a ‘rock bottom’ experience.

The common motivating factor was to lead a non-drug using way of life with ‘normal’ roles and lifestyles. But once the decision was made and the participants entered treatment the conflict between their using and non-using worlds caused problems, which often led to lapses. As well as managing cravings, the changes in self and lifestyle were difficult to cope with, particularly in the light of the stigma and labelling that drug users encounter.
EXPERIENCES DURING RECOVERY

Methadone treatment

As part of their treatment at the SP clients were offered a methadone prescription and weekly sessions with a drug worker. This section deals with the practical aspects of that programme; the clients’ involvement in their recovery; the physical effects of methadone; and the day-to-day problems caused by taking methadone.

Responsibility for change

Participants seeking help with their drug misuse from the SP recognized the personal responsibility they held for changing their lifestyles. Charlie pointed out that SP was providing the ‘support’ and the ‘opportunity’ for change rather than a quick fix ‘but places like this... help. It depends if you want the help. If you're not interested in the help... you know...you come in here, they give you a script, it's to give you an opportunity to sort yourself out, sort yourself out and then you get clean.’

Failure to ‘get clean’ was seen by some participants as arising from a lack of genuine desire for help, as John stated: ‘If people are sincerely wanting to turn their lives around this is the place that will assist them to do that. I know that the advice and help is there...there’s...there’s people who genuinely want to do something about themselves, turn themselves around.’

While it is important that they were aware of the impact of their choices this may downplay the psychological and physical dependence created by using heroin over a long period, and/or the social pressure that they encounter everyday from drug using associates and society in general. Drug misusers might lack the environmental or personal resources necessary to modify their behaviour (75).

There seemed to be a belief among participants that SP workers supporting those on methadone tried to use a non-directive approach, putting the emphasis on the client working through things at their own pace. Michael told us: ‘...there's no instructions from the counsellor...this is what you need to do.’ No it's about you realising these things at your own pace, yes, under your own steam sort of thing.’

Participants used the term ‘counsellor’ when referring to both drug workers and generic counsellors so we are unable to differentiate between the two services provided in this report.

Value was attached to the programme being paced to suit the individual, particularly with clients dealing with past trauma. Michael said:‘ Some people might find they aren't ready to face up to things that have happened to themselves...there has to be a system in place so that people ...sort their problems out over a period of time.’

Long-term drug users are often under pressure from prescribers to ‘clean up’ under threat of dose reduction (3) so having a space to work at their own pace is valued.

However, while participants were happy with the pace of reduction, they felt that relapse and programme non-compliance was sometimes handled too harshly. Helena told us ‘It's like my doctor says 'you've had a relapse' and he's kicking me off so he's not giving me a chance.’
While the ultimate decision to withdraw a prescription comes from the doctor, counsellors were also seen as being too strict.

'I think the counsellors need to understand more that you might not get off it the first time and not just kick you off it you have used drugs. They need to realise that it's not just as easy as stopping right away.' (Questionnaire response)

This feeling of being unfairly ‘thrown off’ the programme could potentially affect the relationship that counsellors have with clients. Perhaps there is a case for lapses or rule infringements to be dealt with more flexibly as the client is settling in to treatment (17). However, one participant did feel that the system had its benefits, as Mark told us: ‘It bucks people up. Gives them a...a shove. If you know what I mean, it’s “buck up - you’re in this serious, there’s people waiting on a list and you’re messin’ about.’

For other participants the non-directive counselling sessions were not seen as being particularly useful.

'It helps but at other times when you’re sitting there and they’re saying stuff that you already know you think ‘I already know this, I know what I got to do, I know what I want to do’ and, you know what I mean. Sometimes no matter what they say it just, you already know what you’ve got to do and what you want to do, because you’re the one that’s actually doing it.’ (Group interview)

Some participants felt that more structure in the sessions was needed. Donna told us: ‘they are quite helpful. There ain’t really a lot they offer, just chatting really.’ The self-empowerment philosophy that underpins the approach used in the SP may not have suited Donna and this may also be the case for others who needed more input from professionals than can be offered in a community setting, needing instead residential detoxification.

Methadone

One of the main negative experiences of treatment described by participants was related to being on methadone. Methadone is said to have several benefits, such as providing effective relief of the symptoms of opiate withdrawal, being safe to use for long periods; and aiding social recovery (36). Reduced crime; improved quality of life; reduced use of other drugs; improved family relationships; and improved physical and psychological health have also been reported (36),(110). Despite all these benefits, attitudes of both staff and users are, at best, ambivalent (111). In one study participants reported distressing side effects and general ‘hassle’ when trying to give up using methadone, over one third of their participants said they would not have started taking methadone if they had known what they would experience (110). Our participants also reported negative effects of taking methadone.

Physical Effects of Methadone

Clients’ dislike of methadone is well known (112); (113). Side effects such as constipation, sweating, weight gain, dental problems, nausea, depression, reduced sexual desire
and amenorrhea have all been reported (36) but the most common reason for their dislike of methadone is that it is ‘worse to come off than heroin’; (114). This too was echoed in our interviews. Charlie said: ‘I was in more of a state coming off the methadone than I was heroin.’ And Gavin told us: ‘If you come down to 1ml of methadone, at the end of that you’re still going to suffer anyway.’

However, it has been claimed that the major problems for clients using methadone are in adjusting to its non-euphoriant effects and then the longer term prospect of living without drugs (115). This does not fit with our findings. Participants reported that they needed to continue to use heroin to avoid withdrawal, in effect no longer experiencing the effects of taking it (see the section on Physical Addiction in section 2).

**Practical Problems**

As well as the physical problems caused by taking methadone, participants complained of the related social and practical problems.

The waiting time for a prescription was seen as a serious limitation of current practice. One questionnaire respondent reported waiting six months for a prescription. During this time the person carries on with their current lifestyle with little support for change, and over time their motivation may decrease. Gavin explained the dilemma this creates:

‘...and you go to see someone for help and they say “oh yeah we’ll put you on the list”. There’s 20 people before you ...so you’re looking at a couple of months, three months wait...so you gotta keep funding your habit, so that means so you gotta keep going out and doing crime....’

And Donna reiterates this view:

‘So you’re ready to get off it so you go to get the appointment but you can’t get [one], you can’t get the script until you get an appointment. You’re just using all the time, it gets worse, because you don’t ... go to get a script until you’re really ready to get clean, but then you’re waiting, and by the time you get a script you might not want to do it then, just carry on using drugs.’

Clients who had to wait for 10 weeks showed slower reduction rates than those who started treatment straight away (116). In spite of the recommendations made by the Community Care Act in 1993 waiting times for treatment have, in general, increased and those waiting longest are men of low socio-economic status, those on probation, and clients with referrals from drug agencies and social services (117), probably those who are most at need.

Some clients state their concerns about the stigma associated with having to take methadone in public. The review of the Bristol Shared Care Scheme Scott, (9) also found that the largest complaint about the scheme was about supervised consumption of methadone. The problems reported were: having to attend the pharmacy regularly, the associated difficulties with employment and the public nature of taking it (with negative reactions from others and the exposure to other users being mentioned).
Michael told us that having to take the methadone at the pharmacy was an unpleasant experience: ‘...you go to the chemist and quite obviously people judge you. Just feel these things you know, you just pick it up from people, because obviously you’ve got to drink the methadone in front of people, it’s quite humiliating because a lot of people nowadays know what you’re doing, and so that in itself isn’t nice.’ Many methadone users feel that collecting methadone from the pharmacy is too public and that they are often made to wait longer than non-methadone customers (110). The ‘addict’ identity is socially visible, even though the individual may have come to view themselves as ‘recovering addicts’, and negative public reactions contradict the safety and acceptance they experience at the SP.

The need to attend the pharmacy daily was also reported to cause problems with finding or keeping a job. Gavin told us: ‘...it’s like when you’re on methadone you’re tied [to a particular chemist] so I could start work tomorrow - it’s like a 6 o’clock start- and the chemist don’t open till 9....’

Conversely, holding down a job can interfere with methadone treatment by causing problems keeping counselling appointments, and the failure to attend might lead to losing the right to a prescription, as Neil pointed out: ‘I was working at the time and I couldn’t get into appointments. You can only miss, I think, its two appointments and you’re kicked off.’

As mentioned earlier, having a stake in normality (101), such as being an employee (99) can aid recovery. The time spent travelling to a clinic or waiting in a pharmacy can interfere with work or with attempts to find work (110). It can also repeatedly bring them into contact with non-recovering users (who may be hanging around outside waiting for someone to sell their methadone), often the very people they are trying to avoid (118); (9).

**Safety and support**

Participants told us that emotional support, formal and informal, was crucial in recovery. The support provided by SP was highly valued. As Charlie put it: ‘..if it wasn’t for the counselling here, I might not have dealt with it so good.’ As well as supporting the medical approach, helping relationships also work as social support (17).

**The Southmead Project as a safe place**

The clients we talked with generally viewed the SP as a welcoming and safe place that allowed them to spend time away from the difficulties of living in the area and their problematic lifestyle. Charlie felt welcomed whenever he came to the project: ‘If you come in here, it's free advice, it's warm, a cup of coffee, and they're genuinely interested in you.’ Michael also commented on the atmosphere within the project: ‘...I've always felt very welcome here and yes, relaxed, it's a good atmosphere.’ John referred to the physical environment provided by SP as: ‘...literally it is [a refuge]. I feel safe here.’

**General support**

As well as receiving help to manage their prescription participants also valued the more general support offered by the counsellors and other workers. Because drug misuse creates changes in lifestyle, issues outside their immediate drug misuse need to be addressed if treatment is to be successful (119). Nick said
about his drug worker: ‘...she's helped me all down the line when really she's only supposed to be here to help me with my drug addiction....’ Charlie also told us: ‘if I needed any information about most things, I could come in and they'd give it, you know.’”

Some of the elements reported to be most important when counselling people who are addicted are: harm reduction; general health advice; changing lifestyle and drug taking behaviours; dealing with cravings; finding ways of coping with stress; enhancing social skills; and focusing on psychological aspects, such as self-esteem, anxiety and depression (36).

**Trust in staff members**

Participants valued the ability to communicate openly in a trusting relationship with their drug workers: Michael told us that the staff were ‘...non-judgemental, which is the key to a worker.’ It was important to Charlie that ‘Jane would talk to me like a normal person would talk to me instead of ‘oh you're a junkie.’”

Workers who enable this kind of relationship have been referred to as ‘the paid family’ (120), providing a relational space in which people can begin to think of themselves as ‘recovering users’, a more hopeful identity than the pathologising and stigmatising identity of ‘addict’ or ‘junkie’. This role was particularly useful for Charlie as he felt that he ‘needed someone outside the home to talk to and sort a way of dealing with it. I mean I knew I had to deal with it up here but then the extra help - that bit extra what helped’.

Participants told us how important it was to talk to someone who understood drug use (and is not a current drug user). As discussed earlier, clients may feel unable to relate to other non-drug users and therefore have limited interactions with them. Michael explained the problems he experienced trying to talk to others: ‘...it's hard to find people that, you know, say friends that you can talk to - absolutely on the level - because often they can't actually handle what they're hearing at all, they don't know how to cope with it themselves.’

Knowing that the worker will not judge them or look down on them, drug users feel able to show parts of themselves usually kept hidden and drug workers or counsellors become confidantes (17). Within this safe and trusting relationship clients find new ways to cope with distress that may have previously been dealt with by using drugs. It has been recognised that when people who have used drugs to avoid the pain and distress of trauma begin to reduce their intake of substances, they are at risk of being overwhelmed. Paradoxically, it has also been recognised that recovery depends upon releasing people from the fear of being overwhelmed by providing them with alternative resources for healing. Koski-Jannes, reported one of her participants saying ‘When I began to feel, I also began to recover.’ (p.197). (105)

**Family support**

Although the SP is seen as a place of safety clients also need support outside to reinforce the changes they have made.

Many participants reported that support from at least one family member was very important in their recovery. As mentioned previously, some drug users may cut their family out of their lives or their families may have rejected them as their drug use escalated. Re-establishing
contact with non-drug using family members may be a way to remember and rebuild a sense of who they used to be and re-establish a ‘stake in normality’ (120). However, this may prove difficult when earlier events have placed a strain on family or social relationship. Helena’s experiences are typical of some of the younger users:

‘They said either you get off drugs or move out. I didn’t feel ready because at the time I was seeing an older bloke and I moved out into a flat and they didn’t talk to me if they saw me out in the streets. That was my lowest point.’

Ongoing drug use can be the cause of family arguments. Parents and friends might give up trying to help drug misusers who repeatedly steal from them to support their drug habit (67). Some families may find it too difficult to risk having their trust betrayed again. Eventually, they may come to believe that any attempt the drug misuser makes to re-establish contact is fuelled by a desire to gain their trust in order to steal from them again, rather than a genuine desire for a supportive relationship.

On the other hand Eddie appreciated the opportunities provided by SP to work things out for himself without involving his family:

‘I’ve kept the project and my private life separate and if things get too much for me then I come up here and I get it off my chest and I don’t upset the family because sometimes you say things which are a little bit hard for them to take.’

Separation from family might also prove an important step towards recovery for some clients who have been enmeshed in an unhelpful family dynamic. Sometimes parents need to demonstrate ‘tough love’ in order to preserve their own emotional and psychological health and well-being, by asking a drug misusing son or daughter to leave home. This can enable young people to take the necessary step towards independence and develop a realisation of the responsibility they have for the choices they make. For caring parents this can be a painful decision which can be interpreted by their offspring and outsiders as abandonment.

So whilst some clients may have the stabilizing effect of family members to rely on, others do not. For those who lack family support the SP represented a substitute supportive ‘family’.

Summary

For the clients of the SP, and most other drugs projects, methadone is the main substitute prescribed as a means to detoxify. Even though it is so widely used clients dislike it. The side effects of taking methadone are unpleasant and withdrawal is thought to be worse than from heroin itself. The rigid adherence to regular doses means that employment is difficult to find or maintain, and taking it in open view of non-users in the community leads to a feeling of being judged. Despite this, the desire to give up using drugs is so strong that drug misusers do agree to the methadone programme. Even though they might not be successful at the first attempt the majority return to the project after lapses and start again.
The SP provided a space where participants felt safe and where they were treated with care and respect. For some methadone users, the basic need for positive regard was met alongside medical treatment. Gradually, trusting relationships with SP staff members, enable clients to develop the skills for repairing and rebuilding other relationships, notably with family members, who may be able to support them further in their process of recovery.
RELAPSE PREVENTION THEMES

Once clients stop misusing drugs a high percentage have been found to start again within a short period of time. One study found that 60% of their sample used heroin within one month after leaving treatment, and half of those used within three days of leaving (121). Other studies suggest that relapse can be as high as 90% after ending treatment (122); (123). In another study (124) two thirds of the clients used drugs within a short period of leaving treatment but did not necessarily go on to fully relapse. Not every use of heroin indicates a return to problematic use: a single slip or mistake is defined as a lapse, whereas a relapse implies that control is lost completely (125). Lapses may also occur during treatment when clients use other drugs alongside prescribed methadone.

There are thought to be four general situations that lead to lapses and relapse; negative emotional states (possibly emotions that were previously suppressed by drugs), interpersonal conflict (conflict with friends, partners, family members, etc.) and social pressure (direct or indirect social pressure to use drugs), (126). Lapses tend to result from social factors, and relapses from individual factors, such as stress and other negative emotional states (127).

Lapses can be devastating for clients, and result in negative psychological consequences, health problems and possibly a return to their previous chaotic lifestyle (128). In their review of the relapse prevention group at the Bristol Drugs Project, Ayers and colleagues (129) recommended the use of a community based, direct-access street project to promote positive change within individuals and communities.

Relapse prevention groups are intended to allow members to gain a fuller understanding of themselves and their drug use through the development of mutually supportive relationships, aided by the group (128). While relapse prevention groups have been seen to be effective, little is know about the active components with the individual programmes (130).

For this study, a group interview was carried out with five members of the relapse prevention group in the same time slot as their regular meetings, one week after their final session. We were interested to learn how they experienced the group sessions and what it meant to them. Group participants were later invited to engage in one-to-one interview around six weeks after the sessions ended, and two clients from the original group were re-interviewed then. Clients at the SP usually attend the relapse prevention group whilst still using methadone, rather than waiting until they are no longer using any drug, and there are no limits to the number of times that they can attend the group. In our sample, two of the participants were attending their first group, two had attended several and one had attended a previous group.

Insight and coping

A primary goal of relapse prevention is to help drug users identify and cope with the pressures and problems that increase the risk of relapse (131). When asked what they had hoped to get out of their time in the group the participants told us they wanted to gain insight
All of the clients interviewed had experienced periods of abstinence punctuated by lapses, and were keen to learn ways to identify what triggered them into lapsing and how to break the abstinence/lapse cycle - a cycle often experienced by drug users in their ‘treatment career’ (132), with the periods of abstinence that lasts from days to a few years (108).

Lapses are thought to be the result of clients failing to recognise how they make multiple complex choices that set them up for ‘a fall’ (133, 134).

One of the reasons participants gave for relapse was that abstinence allowed feelings previously suppressed by drugs to come to the surface. Stress, anxiety, depression, and other negative states are related to relapse (125). The conversation reported below from the group interview shows us how our participants viewed intense emotions as problematic particularly when they have been suppressed by drugs:

**Male 2:** ‘All...all the drugs do is puts your head in the sand. (yeah) An’ then, once you take your head out the sand...

**Female 1:**...It's back again

**Male 3:** Its there again. You have to deal with them at some point, and get through them sober at some point ...to heal.

**Male 1:** ...when you ain’t on the drugs like, you burst our crying - for no reason.

**Male 3:** But when they do come back after taking drugs they seem a lot heavier as well.

**Male 1:** Because you're not as strong - not emotionally as strong...to deal with it, these feelings, never had feeling before, and then all of a sudden you got all this coming out, and you don’t know where...

**Male 3:** ...where your heads to. You knew as soon as you wake up, if you were going to relapse that day. It hits you like a ton of bricks, the emotion that you're trying to suppress, ...as soon as you open your eyes, an’ you know from that moment on that you're going to go and get dressed and you're going to relapse.’

When drugs are used to cope with stress and negative psychological affect, it seems obvious that they would lapse when faced with such feelings again. After managing their distress with drugs, for several years in some cases, drug misusers have to learn other ways to cope. While such issues would have been discussed as part of their 'script' management or counselling sessions, there is a continued need to address the triggers in greater depth as part of relapse prevention group work. Matt told us: ‘we were looking at ourselves, [our] triggers for why we relapsed, also about our feelings and emotions and like why we suppressed those feelings and emotions with drugs.’

As well as dealing with negative emotions, participants named boredom as a major trigger for lapses. Matt told us: ‘[when I say to myself]
“Oh I’m getting bored”, that’s the danger sign, as soon as I think “it’s boring”, that’s one of the danger signs.’

Matt explained that boredom has set in drastically as a result of changes in his daily routine since coming off heroin ‘because like when you’re out using it takes up your whole day and whole life.’ The limited availability of employment in certain areas can be a particular problem when tackling boredom (36).

A group interview participant gave a slightly different view on boredom:

‘You can’t get that natural...feeling when you’re off drugs, you get so bored, so quickly, so you have to take the drug...to stop you from getting bored. Even to keep you to sit still and watch television.’

It has been suggested elsewhere that the non-euphoriant effect of methadone is more difficult to adjust to than the prospect of being without drugs (115).

As well group work helping members to recognise the triggers that lead to a lapse, clients were taught ways to deal with them. As Matt put it: ‘I’ve got some tools to help me instead of just going out and using; I’ve got some tools to help me to not relapse.’ Some of the strategies mentioned as helpful were: talking to friends, family or groups such as Narcotics Anonymous, and avoiding drug-using friends and neighbourhoods.

Learning new coping skills is a key element of relapse prevention group work, including the cognitive/behavioural skills to cope with specific scenarios and general stress inducing strategies (126). Such strategies include removing themselves from environments and friendships associated with their drug-using past; developing a new drug-free routine; and finding new ways to occupy their time that complement their drug-free status (88); (135); (108). The use of cognitive, avoidance and distraction techniques have been found to be successful in aiding abstinence (121) but individuals may actively choose not to implement such coping responses (136) and make the decision to use drugs instead (137). So it appears that simply teaching ways to deal with temptation is not enough to prevent lapses: there also needs to be a conscious decision not to use drugs.

Mindfulness

Another reason for joining the relapse prevention group was the belief that members had to be constantly reminded of their drug misuse in order to avoid complacency that might lead to lapsing. The possibility of lapse was discussed in the group interview: ‘It’s always gonna be there - we’re always gonna be addict...addicts, aren’t we? Even if we been clean for three years...you can easily stick back up.’

For another group member regular attendance of the relapse prevention group was one way of keeping recovery in check:

‘I find like if I don’t go to the groups ...for a couple of weeks, ...I won’t come back. Then I won’t go asking for help so I’ll just carry on ...I’ve done 3 relapse prevention groups now and I’ll keep doing them as long as they’re going.’
Findings - Relapse Prevention Group

Participants also talked of substituting one compulsive behaviour for another, for example a compulsion to shop, clean or drink alcohol. The talk was of a general ‘disease’, of addictive behaviours or an ‘addictive personality’ rather than seeing drug use as a coping mechanism, as stated in previous discussions about using drugs to cover up emotions. The adjustment to living without the aid of a mood altering substance can be one of the biggest difficulties in coming off drugs, and often the switch is made to other drugs or alcohol (36). Substitution can constitute a considerable problem for recovery:

‘...numerous studies estimate that at least 20 percent of former addicts go into heavy drinking and subsequent alcoholism or end up in a state of mixed abuse of alcohol, sedatives and hypnotics.’ (p.345) (138).

This also suggests that the reasons behind the compulsive behaviours may not have been fully addressed nor appropriate new coping skills developed. It is common to hear clients describe their urges and cravings in terms of being held firmly in the grasp of ‘a monster’ (126). The person may hold onto a more positive sense of self or identity by viewing addiction as a disease or personality type, and thereby lessening the moral blame often laid onto problematic drug users. However, the disease concept may also offer clients little room to move beyond the idea that their addiction will always be a part of them.

The benefits of group work

Group members viewed the chance to share their experiences of problematic drug use in a group with others as beneficial, and a way of reducing a sense of isolation. Group discussions also opened up the opportunities for receiving practical help and the participants welcomed the opportunity for learning from each other new ideas about different ways of coping.

The problems with developing meaningful, supportive relationships (discussed in the previous section) meant that there was normally little chance for participants to discuss with others their temptation to use drugs. A group interview participant told us that on meeting new people who were friendly towards him, his initial thoughts were: ‘What d’you want? What are you after?’ This mistrust left participants trying to cope with temptation on their own rather than accepting support from others. Matt explained how important it was to use the support of others to steer himself away from temptation; ‘if you’re left with it on your own you’ve just got your own mind to deal with and you’re halfway ...to convincing yourself that you’ve got to use.’

The opportunity provided by the group to discuss their experiences with people in the same situation was greatly valued, as this extract from the group interview shows:

**Male 1:** ‘Erm...that other people have gone through it exactly the same things. You’re not alone - you’re not mad.

**Male 3:** You’re not mad - you’re not alone. Know what I mean - there is light at the end of the tunnel. There’s people there that’s proved it.’

The unease that participants reported about establishing relationships with non-users was overcome by having other people in recovery.
with whom they could discuss their problems. A male participant in the group interview told us:

**Male 3:** 'It's easier to talk when you're in a group, 'cos you know everyone's in the same boat (yeah) so you're not embarrassed...to bring out what your problem is, because, you know, their problem is...there's someone else...''

In spite of having a counsellor or drugs worker to talk to, it seems that participants felt more comfortable talking to peers in the group. Sharing with each other was viewed as more beneficial than sharing with a professional whose advice was seen as less ‘authentic’: them having not necessarily experienced problematic drug use themselves.

**Supportive relationships**

As mentioned above, recovering drug users can experience feelings of loneliness and isolation as a result of cutting themselves off from old friends and being suspicious of the motives of new people (108). Loneliness can be a high risk trigger for relapse as drugs may temporarily relieve feelings, and the social use of drugs may provide a sense of community (126). A participant in the group interview pointed out:

‘You just...and you gotta change your friends...and it’s nice to know that...there's someone there who is 100% dedicated on staying clean and...so you can become friendly with that person and you do it together.’

As well as teaching coping strategies, the relapse prevention group fosters supportive friendships, and in turn, the development of drug-free social support enhances relapse prevention efforts (139). Mark told us: ‘We’ve found a group now...we’ve just got our little group and we’re all fighting it together, pulling each other up when [we’re] down.’

Whilst individual needs might best be met within a counselling relationship group work can promote social support, encouragement and the space to practice new skills (140); (131).

Having supportive friends and family members was also identified as useful for life outside the SP. Some participants in the group interview felt that they were not always ready to talk during designated group sessions so the ability to find support from their peers outside those times was necessary.

**Male 3:** ‘There’s days that you could talk all day about it. So...it...it’s nice to be able to...The drop-in is only open twice a week...so you’ve got to try and be able to talk on them two days. But them two days you may feel down.’

Two group participants who gave one-to-one interviews used metaphorical language that emphasised the connections group members made from sharing their experiences whilst also focusing on the value of the group as a means of helping people at different stages in recovery Mark said “there’s people further on in the tunnel than others you know, which is better, it’s passed down the line” and that the
support that they provide for is each other is ‘like a tag, tag team.’

This sense of connection lessens feelings of isolation and provides a shared reality. Matt told us:

‘I mean it’s a case of just remembering that you’re not alone, that you’re not, um, and you’re not insane and there are other people, other people are going through exactly the same as what you are and like they need help as well.’

However, it was acknowledged that there was also a need for one-to-one sessions with their counsellor or drugs worker. Matt said: ‘…there are drawbacks obviously because of it being a group: there are things that you don’t want to come out with, but you’ve got your one to one sessions to do that.”

One of the limitations of group work, noted by (36), was the possible impact on abstinence of group members who reminisce about enjoyable shared drug using experiences. However, our participants acknowledged that even though enjoyable experiences were shared in the group, they also talked about many negative experiences - often their most recent experience that led to a decision to give up drugs:

Male 1: ‘We got on drugs and we carried on doing drugs because they were nice. If they weren’t nice we wouldn’t have done ‘em. So there are good times.

Female 2: Where you’ve had a laugh...

Male 1: Yeah, you’ve had a laugh. But those people that we can reminisce about - we can always reminisce how bad…”

Instead of recounting only pleasant experiences they had created a group discourse where drugs are viewed as negative, changing from the discourse of ‘an enjoyable pastime’ to ‘a problematic lifestyle’.

Social context is seen as an important element of behaviour change and the ability to maintain that change (109), and in the relapse prevention group there was a shared belief that drug use was undesirable. Participants were aware of the potential impact on other members of their own lapses and, rather than bring other people down, they were more likely to talk to their counselor about it in individual sessions. In the group interview we were told ‘If you’re gonna relapse, relapse on your own - don’t drag someone else down with you when they could be doing well. That is totally unfair.’

This view could be interpreted as a measure of the participants’ investment in-group membership, (which depends on upholding the groups’ stance on drugs), in an effort to avoid reverting to ‘outsider’ status and losing important relationships.

The importance of relationships can also be seen in the extract below from the group interview. Here they mimic the kind of conversation held when a dealer uses ‘fake’ friendship to gain trust and continue doing business.

Female 1: ‘Yeah, [they say] “I’m going off for a smoke now”

Commissioned by the Southmead Drugs Project and funded by the European Social Fund and HEFCE.
Male 1: “here’s me number - if you ever wants a chat or anything’...
Male 3: OR “here’s a tester, you been clean for ages...here’s a tester” - what you gonna do?
Female 1: What you gonna do? You ain’t turning that away.
Male 1: Or like, you know - “d’you fancy coming for a drink?”
Male 3: They create...the...addicts. They create ‘em so they got more customers. And then they tempt you “oh, I forgot me money”, “well, I’ll loan you the bag.”

This conversation reminds us of the social nature of early use where drugs were used as a leisure activity with peers and may go part way to explain why the participants’ reported being suspicious of friendly approaches.

**Active in group/ownership**

The sense of connection with other members of the group, and the space to come up with their own answers, gave participants a sense of agency in their own recovery. When they started the group they were looking for insight into and triggers for their drug using behaviour which was gained through discussion with other users rather than direct instruction from the group leader. Matt told us that in the group ‘...there was not one answer that you've come out with, but there's ten answers’ and that ‘everyone’s got their opinion and everyone’s got their way of doing things.’ One group interview participant concluded ‘...and eventually, between the lot of us, we come up with an answer.’

When talking about his time with the group Mark felt that his input as a member had helped shape the groups current format: ‘...we've done lots of relapse prevention work and we've put a lot of input into it...we've got the method now.’ He also talked of one of the group members acting as leader, facilitating discussions and putting others at ease - emphasising the peer group nature of the group, rather than one led by professionals. The ability to help someone else in the group was seen as a source of self-respect. This kind of involvement can help lessen feelings of isolation, essential in fostering a satisfactory social identity (107).

**Giving Back**

As well as being active within their relapse prevention group, the participants were keen to give something back to the project, to other drug users and to the local community. The two participants who gave one-to-one follow up interviews were both active members of the service users’ group at the SP and were involved in creating newsletters and posters to ‘make people aware that not all drug addicts are scum.’

As well as trying to change the community’s perception of drug misusers, this involvement has the practical benefit of increasing opportunities for accessing the SP. As Matt points out: ‘I’m allowed to come in ...on the days that the project isn’t open [to clients], which is like brilliant for me because it gives me somewhere safe to go and it also gives me something to do.’ It seems then, that the desire to be actively involved in the work of the project, where clients feel safe, helps them avoid boredom (which can lead to lapsing), and to experience the positive feeling resulting from being engaged in enjoyable and rewarding activities (129). Additionally,
undertaking activities in the 'safe' environment of the SP reduced the likelihood and opportunity of contact with old drug-misusing friends, (whilst still living in the same community), and therefore, the temptation to use drugs (108).

Long term drug misusers, or those who started using at a young age, may find that they lack non-drug using peers, and when they no longer have the desire for a drug using lifestyle they need to build both relationships and lifestyle (36). Non-drug related activities and friendships can help build and sustain a drug free identity, and the prospect of a more satisfying and rewarding future (108).

**Issues of self**

Participants saw their drug misuse as being a major influence in shaping the person that they are today. In the interview they questioned how they and their lives might be different if they had not become involved with drugs. As one group interview participant put it: ‘You don’t know who you could have become.’

As discussed in the previous chapter there was a split between who they considered themselves to be now and who they were before misusing drugs (87). The stigma attached to his ‘addict’ identity led to Matt thinking: ‘if everyone thinks I’m shit I might as well be shit’, illustrating the influence of social forces on defining identity. A client’s sense of self and identity has to be built and defended against a variety of such pressures during treatment (108). The supportive nature of the group and the feelings of connection with other members fostered a more positive self-outlook for some participants, as Matt explained:

‘I got low self-worth and self-confidence. I feel that what I’ve got to say isn’t worth anything and this group sorts me out - my opinion does matter.’

As part of the relapse prevention group clients are able to select an activity for a day trip away from Southmead. There was general agreement that the trips, which usually involve some form of outdoor activity, such as fishing or canoeing, are beneficial as they remind clients of the possibility of a life beyond drug use. In Mark’s words ‘they ‘really opened the door to the kind of life that we’ve been leaving behind’ and provided ‘a bit of insight of what I’ve been missing out on all these years.’ The day trips were mentioned as one of the most beneficial aspects of belonging to the relapse prevention group, giving clients a glimpse of a lifestyle away from drugs which, as Mark explains, becomes a ‘day-to-day routine of not sleeping, staying in your community finding drugs and shutting off to all your emotions.’

**Women missing out**

When asked what was missing from the group one male participant suggested that there were too few women attending the groups. It was suggested that as well as bringing a wider range of perspectives, women suffer more stigma than men and therefore may have more need of the group

**Male 1:** ‘One thing is there’s not a lot of women. It’d be good to get their perspective. Cos that’s different isn’t it and it’s harder as well, ’cos a girl gets a worse name.

**Female 2:** …and ‘you’ve got your children…”

**Female 1:** “you’re a bad parent”
Female 2: “Oh, look at her dragging the kid around - taking it out shoplifting.”

One female participant identified lack of childcare as the main reason for her not attending the relapse prevention group:

‘See, I got real bad trouble with childcare. That’s why I couldn’t come to the last one - I couldn’t exactly take him. I got no family in Bristol - no, really, friends - I can’t leave him with just anyone, I got to take him everywhere with me.’

While this means that women are less likely to attend such groups, having children also means that they are less likely to be exposed to peer pressure and social situations that encourage lapses, therefore men may be more in need of relapse prevention services to cope with such influences (141).

Summary

Participants told us that the relapse prevention group provided relationships, a sense of connection with others, and an opportunity to form mutually helpful relationships that led to a growth in self-esteem. Outings also provided opportunities to experience different kinds of lifestyle activities.

Clients joined the group with a desire to understand their own cycle of abstinence and lapse, and found that they also gained social skills and personal development. Sharing information with other clients in a group reduced the feelings of isolation and sharing experiences, particularly negative experiences, also led to a shared group norm of ‘non-drug use’ and further increased the sense of connection with others through a shared goal. The shared goal of staying drug free helped them create networks where they could ask for help and support when threatened with lapsing and where they could offer their help to others in return. This mutuality in giving and receiving helped to increase self-respect and self-worth and develop a sense of agency in their own recovery. Feeling a connection with others and being able to provide help also allowed a supportive space for positive identity change.
DRUG WORKERS’ THEMES

Background

Previous research has emphasised the importance clients attach to having a good relationship with their drugs workers, pointing out that a failure to build such a relationship was a common factor in clients dropping out of treatment (142). Drugs workers’ beliefs and approaches to treatment can influence the success of any therapeutic venture (143). The relationship between clients and drugs workers can become strained after recurrent lapses and the management of such strain is an important feature of methadone treatment delivery for workers (17).

Three drugs workers were interviewed about what it was like for them to do their work. We were interested in what led them to this area of work, how they approached the work and what impact the work had on them as individuals. They were all experienced in carrying out ‘script management’ (supporting service users who were receiving methadone on prescription from GPs); outreach work; and counselling. Prescription management and counselling differ in that the former is focused on clients’ immediate problems that affect their treatment, whereas counselling sessions involves a process, usually over a period of time, and usually deals with fundamental issues. Outreach work involves creating links with other organisations, needle exchange services; and providing information and education, and raising awareness of drug related issues.

Out three participants did not set out intending to pursue a career in counselling or drugs work. They had all moved into the field after experiencing a range of life experiences. Two of the participants had experienced problematic drug use themselves and moved into drug work following their recovery. The other participant had moved into drug work after taking a counselling course.

Approach to the work

The workers discussed what they saw as their role at the SP and how they approached the work.

Treat whole person not just addiction

Participants all acknowledged their belief that there were varied and complex reasons behind problematic drug use and that therefore their work needed to cover more than just clients’ problems with drug misuse. As Judy explained ‘if one area in their life is not good then you need to look at the whole picture and not just focus on the drugs.’ Clients might bring problems with housing, employment or education. Rachel told us ‘...some clients have got very complex needs and drug addiction isn’t just about treating the symptom or just getting them off the drugs - it’s a bigger picture really.’ This fits with what clients told us in the first section of this report: that other aspects of their lives need to be taken into consideration, like parts of a puzzle. If their needs are to be fully addressed they might require help with inter-personal relationships or roles and responsibilities - which may be the very aspects of the person’s life that have fostered and maintained their problematic use.

Drugs workers told us that clients need someone to help them tell their stories, without judgement or condemnation if change was to occur. Rachel told us: ‘I think they need to be
listened to and valued, not judged.’ This statement indicates the perceived stigma and feelings of isolation that clients told us arose from their own and others’ perceptions of what it means to be an addict: that they were written off as ‘dirty junkies’. Drug workers recognised that being non-judgemental was one of the most important qualities they could offer this client group, something that was confirmed by service users themselves. An accepting and non-judgemental relationship provides the client with a safe space to experience respectful interaction with another, allowing them to regain some sense of selfhood that extends beyond their drug misuser identity, and thereby removing some of the perceived stigma that blights other non-drug related relationships. As Judy told us: ‘you naturally see people start to change because they are being heard, and people believe [in] them.’ The ability to interact with a trusted person in such a way may provide the ‘stake in normality’ (101).

User led treatment

Participants also discussed the importance of taking clients’ opinions seriously when negotiating the required dose. As Judy points out: ‘There’s no point us setting anyone up to fail, so they have a say at the initial assessment and then, you know, we’ll keep reviewing that as time goes along.’ This approach was valued by clients but sometimes pressure from GPs to reduce the amount of methadone used (3) can cause problems between project workers and clients. As one worker explained, this can happen at times: ‘... when your client feels that it’s [dosage] not enough, but it’s something that we’ll negotiate between both of us - we’ll come to an understanding.’ Clients feel their opinions are valued when they are enabled to have a say in their treatment. As well as helping build and maintain rapport this practice enables client to feel a sense of involvement and agency in their own recovery (17).

There are however limits to the amount of influence a client can have over their own dosage. While still allowing the client to state their views workers agreed that there had to be a degree of consistency across different individuals’ treatment programmes: a need to ‘...to give a fair chance to everybody,’ as Judy put it. In the first section of this report we reported that some clients felt resentful if they believed they were treated more harshly than others after lapsing, so there is a need to be seen to treat everyone equally, particularly when it involves the loss of a methadone prescription.

Dealing with disclosure of abuse

Disclosure of abuse was another area where it was important to listen to clients. All of our interviewees and questionnaire respondents told us that they had had experiences where clients had disclosed abuse in their sessions. Rachel told us: ‘It’s important to acknowledge that clients have...had the courage to disclose abuse. I think an acknowledgement [of that] is the most important thing.’ She went on to talk of the importance of this disclosure for some clients:

‘...it’s quite important for them to have a space to be able to talk. They might have a history where they’ve never experienced that [permission], so I suppose there can be some situations where maybe as a worker you don’t value what it is
you do actually offer and the impact that has on the individual.’

However workers believed that it was not appropriate to deal with experiences of abuse during prescription management sessions, preferring instead to refer clients to counselling at a later stage in recovery. As Stuart told us:

‘if they were to start speaking about abuse we would actually say to them that maybe this is not the time... I think its, obviously important to deal with the problem which is actually dependency on a drug, abuse counselling would have more of an impact [rather] than having somebody who would actually be on a high....’

A questionnaire respondent told us that disclosures were acknowledged with respect but clients were encouraged to ‘stay in the present’.

The reasons for referral to counselling were expanded upon in the questionnaires completed by staff from other agencies. Decisions to refer on for counselling when the time was right was based upon: the need to focus on drug misuse; time constraints within sessions; and having no guaranteed continuation of contact when the contract was based on substance misuse work.

SP workers and questionnaire respondents told us that they would listen and acknowledge clients experiences of abuse without judgement. However, they would not delve into their story, but rather focus on the here and now of their drug use.

When asked what they thought were the needs of clients with a history of abuse or trauma one questionnaire respondent told us ‘primarily, [they need] a good listening to.’ They believed this needs a safe space where longer term counselling can help the client find ways to deal with their experiences. Additional help with housing, and peer-led support groups were also thought to be useful later on in treatment.

Experience of doing their work

This section looks at how workers experience themselves in relation to this work.

Relationship with clients

Participants believe that the ability to form positive relationships with clients was fundamental and essential to their work. They saw the main characteristics of their relationships with clients as non-judgemental and respectful. They might first meet potential clients as outreach workers where contact is made that encourages clients to approach the SP once a relationship has been formed with a particular worker.

As well as relationships with their drugs worker clients also form bonds with other clients. Those relationships can also be an important source of support, particularly when relationships with family and friends have become damaged as a result of long-term drug use, and there is limited contact.

It was acknowledged that although it is important to develop a trusting open relationship with clients, there is always an element of power inequality within those relationships. Rachel told us: ‘I think you’d be quite naive not to know that you have some
power and authority within that relationship.’

When clients begin to experience difficulties with their treatment the relationship with the worker can suffer, but as Judy told us: ‘because I’ve [already] got a relationship with them I’ve got that balance of knowing what they’re like when they’re in a good space.’ Within a positive and constructive relationship clients can begin to open up and trust the worker, and the relationship can hold the client through periods of lapse or relapse if that is part of their recovery process.

Impact of own experiences with treatment

Many drugs workers have themselves misused substances in the past (Kolpack, 1992) and two of our participants told us that they had such a history. Stuart believes his own drug using history enables him to empathise with the clients: ‘just having the opportunity to give somebody else a helping hand with their addiction is...is. ...because I’ve kind of experienced it myself.’ As well as creating empathy the worker’s previous drug misuse was thought to aid understanding of the issues faced by clients. For Rachel it gave her understanding of how clients sometimes lie to workers:

‘I think it gives you insight into how drug misusers might think: some of the lies that they tell, ...[they] might try and throw things out which might trick... try to trip you up. But you’d know about stuff [and you might think]...’No I don’t believe that.”’

Ex-drug using workers may also feel frustrated when they compare their own recovery to their clients’, both in terms of how clients handle their recovery and the standards of care offered by other agencies, which does not match the quality of care they had received themselves. Stuart explained:

‘I had to be really aware of my own... recovery process...but also to be aware of theirs and to be respectful of theirs as well. And I suppose at times that can be frustrating...seeing people going round and round in a circle and kinda getting back to the exact same point they left at...when you kind know that...there was actually a process for you and there was actually a way you could have stepped in.... But then again, a lot of the situations have made it a lot more difficult, with other organisations, yet again.’

Another problem discussed was the possibility that drugs would become the main focus of the workers’ lives, both personal and professional. Having a personal history of drug misuse and then working with drug users could leave little space in their lives unrelated to drug issues. This saturation was seen as a potential problem if frustration was displaced onto clients. Ways of avoiding this included having other interests and relationships outside of work, and good supervision.

The potential for burnout and vicarious traumatisation among workers who lack the necessary balance between work and leisure, and the right amount or type of supervision, has been well documented (144); (145)

Relapse

Clients are rarely successful at giving up drugs after only one attempt (100). As discussed in the relapse prevention group section, lapses
Findings - Drug Workers’ Themes

can be devastating for clients (128) but attention also needs to be paid to the effect of relapse on the workers. Relapse can create frustration and pessimism about taking on new clients (125). These feelings can be understood in terms of ‘counter-transference’ when the worker takes on clients’ disconnected feelings and experiences them as their own. If these feelings are not addressed in supervision they can lead to cynicism and despair, and eventually workers withdraw from the field (144). This could account for the high turnover among drugs workers.

However, in these interviews we found that relapse is often expected to be part of the recovery process. As Stuart explains, there are issues in the client’s life that influence their recovery -

‘you can’t guarantee someone is gonna complete the detox and guarantee they’re not gonna use again. Sometimes we do find clients that’ll come down, when they get ....crisis in their life and some may go back to using.’

While clients told us that motivation was the key to successful treatment Rachel had a different view:

‘...sometimes, quite often, they want to stop. Motivation is there but they’re not willing to...surrender or, I don’t know, just trust I think. Trust that they can handle life without drugs or drink.’

Before lapsing clients may discuss the possibility with their drugs worker or counsellor. Judy told us how she manages such situations: ‘people do tell us and we sort of talk through that ... try and work out ways around that, and work out a strategy to try and find out why that’s happening, and maybe look at their dose of methadone, [to see] whether it’s sufficient for them or not.’

So sessions often enable clients to develop an insight into the circumstances that lead to lapse, and work out ways to avoid that happening.

While relapse was seen as understandable in many cases, it still led to feelings of frustration. Stuart told us that: ‘..just to see somebody going round in a circle, constantly. Keep going round and round and round. And not actually moving - sometimes that can be frustrating, but again you got to step back and allow people their processes.’ The frustration experienced when a client does not make progress can also make further therapeutic relationships difficult, as Rachel explained ‘...when you’ve treated them for several treatment episodes it can be difficult not to bring in that history with someone you might have worked with before and they’re just playing the same patterns.’

While repeated relapses can be frustrating it was acknowledged that each lapse could provide new information for subsequent sessions. As Rachel explained: ‘a relapse can be beneficial later on because they can look up what weren’t they doing, and what could they do differently.’ In this way sessions held following lapses can help the client gain further insight by looking at the factors that led to it.

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Measuring successful outcomes

When asked what they considered a successful outcome, participants saw this as more than giving up drugs. Stuart spoke of successful outcomes in terms of enjoying the relationships he had with clients, and being rewarded by seeing clients find stability in their lives and develop as a person.

Rachel told us that she gains reward:

‘... just watching them enjoy life rather than endure it ... just seeing ...people at peace really and not running around and coming out with the most extraordinary lies and not committing crime. All of those things I think would be deemed as a success, [or] improved relationships with family, and staying out of custody.’

Judy told us that the client’s personal growth was rewarding for her:

‘So for me it’s actually to see that transition from people being shrunk as people, being small, and then just to see them flourish and take a pride in themselves, and being on top of things, and start to look after themselves.’

With relapse still being the norm, the satisfaction gained when someone does move towards recovery is highly valued.

Relationships within the project and with other agencies

Workers experienced the team at the SP as generally supportive. Management and other workers were open to new ideas and particularly helpful when workers were faced with challenging clients. However, the high rate of staff turnover, which is common in drug services, was seen as a drawback. Participants believed that when staff leave the project clients’ growth and development is hampered by having to begin again to build up trusting relationships with new staff.

The participants felt supported by the GPs with whom they worked. While the GPs have the final say on prescriptions and dosage, participants felt that their opinions were listened to and that there was mutual respect for each other’s work. Workers felt that it was advantageous to share with GPs the responsibility for decisions about treating relapse.

Participants discussed problems related to current policy. The length of the waiting list was still a source of frustration for staff as well as for clients, and there was a recognised need for improvement. As Stuart pointed out: ‘...what’s hard for me is seeing somebody getting to the point of contemplation and actually asking for help, and then they’re told that they [need to] just hold that crisis for another 6 or 8 weeks.’

Participants stated that methadone was not suitable for all clients and they shared clients’ concerns that it can be as difficult to give up using methadone as illegal substances. However, in some medical centres there was nothing else on offer.

Summary

One of the main tasks for workers who support clients on methadone was the development of
a positive relationship with clients. This relationship involved building trust with the client so that they could explore their feeling and experiences within a supportive relationship that may be unavailable elsewhere. The client’s involvement in negotiating the dosage encouraged a fuller engagement in the treatment process and a sense of agency over their own progress.

There was, however, some acknowledgement that the workers ultimately have power over clients’ treatment although sharing decisions with GPs helped to maintain relationships with clients. Clients’ desire to ensure that treatment was consistent for all could limit flexibility in their work. The inappropriateness of discussing abuse in prescription management sessions also restricted the degree to which clients could lead the sessions.

The common occurrence of relapse was a source of frustration for workers who sometimes felt that their work was in vain. Workers who had personal experience of drug misuse were also concerned to ensure that their own experiences of recovery did not negatively impact on their work, but when faced with clients who were being denied the level and quality of help they had received themselves this added to their frustration about local policy. Workers felt rewarded by the relationships they were able to form with clients and by seeing them develop, even when they were still experiencing drug problems.
CONCLUDING REMARKS

‘….what I’m working towards is having different facilities for children who are experiencing this stuff, because tomorrow’s addicts are children now. And also to look at parenting: we’ve got third, fourth generation alcoholics, drug users, and domestic violence in particular, so in order to break that cycle I think we need to invest in children and families. That’s my belief.’ (Mike Peirce, Chief Executive SP)
SUMMARY OF THE RESEARCH

This study explored a range of views of the services provided by The Southmead Project to gain an understanding of drug misuse, treatment and aftercare and the processes involved. The relationship between historic abuse and trauma (while being covered in depth by Dr Kim Etherington in other publications) has also been given some attention.

In the introduction we outlined some of the recommendations for good practice reported by Shaftoe (1), The Shared Care Review (9) and The Audit Commission (8). These included: extended aftercare for clients that considered: the need for a flexible and client-centred model of treatment meeting the complex needs of the whole individual (12); positive relationships with staff members; support for parents; and early intervention to prevent child abuse.

This section provides a summary of the main findings from the study and examines how the recommendations made above are reflected in our participants' accounts.

There are several main themes that have emerged from participants' accounts of addiction and recovery, and these are outlined below:

Paths to drug use

Participants responses to questions about how they came to misuse drugs fell into two broad categories: those who took drugs because they were an available and socially sanctioned pastime and those who used drugs to escape from emotional and psychological distress created by current or historical trauma. However it is difficult to separate the potentially traumatic effects of social conditions, e.g. poverty, marginalisation and unemployment (37), and the effects of current or historic significant loss, and/or physical, emotional and sexual abuse and neglect (146); (147), which influenced some participants’ desire to escape reality. Drugs, including heroin, were visible and available in the Southmead community, which has a reputation for social and drug problems. Drug use was also normalised for some participants who had drug using siblings or parents. This group pf people were likely to join in recreational drug use when offered drugs by friends.

Experience of ‘addiction’

The change from recreational to problematic use was thought to occur during a period of emotional vulnerability when the drugs would take hold. Current life disruptions or unresolved background trauma interrupted life narratives; negative events or a lost role led to uncertainty about themselves and their future; and solace was found in drugs. This indicates the importance of counsellor involvement to help clients establish a coherent and functional story that provides positive orientation for the future (85).

It is worth noting that people who had not experienced current or historic trauma seemed able to continue using drugs at a recreational level, or to find their own way out of it.

Problematic drug use caused participants to view themselves as having changed from the person they were before (87), becoming...
immersed in a drug culture and forming a new identity with appropriate drug-based friendship groups, and a lifestyle based around seeking out and using drugs: identities became based around their status as a drug user.

Several participants who were concerned by the stigma attached to people who misuse drugs wanted to distance themselves from other, more problematic drug misusers by highlighting the differences between them and thereby maintaining a more positive sense of self.

Stigma also hindered relationships with non-drug using friends or family and therefore limited potential sources of available support. Stigma led to the development of a negative self-image and contributed to difficulties in seeking help for fear to being viewed as a ‘dirty junkie’. Participants also feared they would not be taken seriously by medical professionals.

**The decision to change**

A key factor in the decision to change appeared to be related to conflict experienced between the ‘old self’ or roles associated with a non-using lifestyle, and their drug misusing lifestyle. Several participants discussed the desire to perform the role of parent and partner. For others, their level of drug misuse had prompted a change in their lifestyle and identity and they had reached a point where they felt that they could go on no longer.

**Experience of treatment**

The physical side effects of methadone and the practical problems of being on a methadone prescription were seen as limiting the quality of life and made their treatment public and therefore open to negative opinion from others.

Staff members reported good working relationships with GPs, but clients felt that their doctors did not take them seriously and that there was little understanding of the problems they faced. Participants also felt that relapses were dealt with too harshly by their GPs, but praised their drugs worker for the user-led nature of their treatment, allowing them to reduce at their own pace.

Participants’ relationships with their drugs workers were described as one of the most important and useful aspects of their contact with the SP. In particular they appreciated the ability to be able to talk openly and without fear of judgement. Relationships with family members or partners were also seen as important in providing supportive relationships outside the SP.

The value that participants placed on relationships with SP staff, friends and family members during recovery, suggests that supportive relationships with others are missing during the time they are misusing drugs. The need for connection with others and a sense of belonging is met through the development of supportive relationships with peers in the relapse prevention group and attendance at drop-in sessions at the SP.

The environment of the SP was seen as a safe place where people were free from judgement. The groundwork for a new identity as ‘recovering drug user’, laid down by their connection with the SP, was built upon by a desire to become involved and give something
back by helping others with their recovery, indicating they were trying to regain a sense of purpose in life. This shift in identification contributes to a positive appraisal of the outcome of drug use and allows for a positive future outlook. Participants commonly reported that they would like more activities at the project in order to provide structure to their days.

**Relapse Prevention Group findings**

Participants in this part of the study told us that as well as gaining insight into their drug misuse and the triggers for relapse, the relapse prevention group also provided: a sense of connection with others; reduced feelings of isolation; and an opportunity to form mutually helpful relationships that led to a sense of involvement and agency over their own recovery and that of others. Relationships formed by sharing experiences addressed feelings of shame and stigma, thereby increasing self-esteem. Outward-bound activities reminded group members that there was a life away from drugs and outside their immediate neighbourhood that they could aspire to.

**Drugs workers’ experiences**

One of the main tasks for drugs workers and counsellors was to develop positive relationship with clients, and this was where staff found reward in their work. The establishment of good relationships helps workers to maintain trust in clients when relapse occurs.

Disclosures of past trauma or abuse during prescription management sessions were assessed as more appropriately addressed by referral to Touchstone (specialist abuse counselling arm of SP) or similar agencies when clients were ready. Referral was due to time limitations and a lack of guaranteed continuous care, as prescription management sessions were only designed to deal with drug problems.

Drugs workers expressed a desire that all clients should be treated equally but this could be at odds with recommendations made in previous studies for flexibility in dealing with relapsing clients. However some GPs were respectful of drugs workers' views of what was most helpful in individual cases and willing to collaborate in the decision-making process. Recurrent relapses were a source of frustration for workers, particularly those who themselves had overcome drug misuse. However, this frustration was more often directed at current policies rather than the clients.

Factors that were thought to hinder drug workers ability to do their job were related to outside agencies and national policies, such as waiting lists or the policies of other agencies that limited their usefulness as a resource for referral.

**Meeting recommendations for good practice**

Overall the Southmead Project is meeting the recommendations for good practice:

They are providing support for other areas of their clients life beyond their drug use by helping, informally, with housing, education, family life etc, they are also focused on building good relationships, both between staff...
and clients and between clients’ and their peers, which can improve treatment engagement and retention, provide extended support networks for the clients outside the project and act as a source of reward for drug workers.

The relapse prevention group sessions provided a space for personal and social development, alongside help with avoiding relapse. The value ascribed to the sessions was reflected in participants’ stated wish to extend the period over which the group was held beyond the current six-week period.

As family relationships may be damaged through long-term drug misuse the Parents’ Group set up by the SP benefits all parties, by supporting and informing family members who are then better able to support their drug misusing relative in their recovery. The Parents’ Group was examined separately and the findings will be communicated through conference presentations and academic papers.

The need for positive relationships with staff recommended in previous reports has clearly been met within the SP as evidenced by participants’ stated ability to communicate openly with workers without fear of judgement or stigmatisation. These relationships were highly valued as a source of positive change. In the light of findings that poor relationships with their drugs workers was a major factor in the rate of client retention (142). SP recognises the need for some people to meet several workers before deciding if trust is possible. Supportive friendships were also formed with peers at group and drop-in sessions (as discussed in more detail in the relapse prevention group findings.

Participants were happy with the flexibility of their work with their drugs workers, praising the user-led pace of the methadone reduction that created a sense of agency in their own treatment. This was beneficial in retaining clients in treatment and encouraging commitment to recovery. However, non-compliance was believed to be dealt with too harshly by some who felt that greater flexibility and understanding should be shown when clients lapse. Perhaps there is a case for lapses or rule infringements to be more flexibly dealt with when the client is first settling in to treatment (17).

Treatment was seen as flexible and client-centred with regard to methadone dosage but factors outside the SP’s control, such as waiting lists and particular GPs approaches to lapses, were seen negatively. This suggests that current practice is not meeting the recommendation of flexible treatment, as outlined in previous reports.
Concluding Remarks

RECOMMENDATIONS

1. Young people should be educated about potential dangers of drug use by local ex-drug misusers rather than outsiders with little understanding of local residents’ lives and the area.

Living in Southmead contributes to residents’ views of drug taking as less serious than is depicted in drugs education programmes. For example, when a person is first introduced to drugs by friends or relatives rather than ‘a pusher’ drugs may be viewed as less dangerous. The euphoric effect of substances used and the bonding experienced by drug misusers may be viewed as enjoyable. There may be none of the pitfalls and unpleasant side effects that are often associated with drug use. All this may cause people to discount drugs awareness sessions as scare-mongering.

2. Opportunities for clients to contribute to the running of the project will provide routine and roles with responsibility.

Loss of role and purpose disrupts the individual’s life narrative when their function and place in society is gone. Seeking out and using drugs fills that gap. There was a powerful need for many to return to a non-drug using life with ‘normal’ roles and lifestyles but the changes required were difficult to maintain.

3. Education about the impact of negative life events on subsequent drug misuse could increase societal understanding and reduce stigma - thereby reducing the requirement for a drug subculture.

The stigma attached to drug use creates a sense of alienation and marginalisation for people who may already feel ‘different’ because of the impact of early or current life trauma. Education about the impact on peoples’ lives of trauma and abuse could create greater empathy and compassion.

4. Mediation between drug misusers and their families, and ongoing support for those relationships can enable the development of trust, forgiveness and healing.

By bringing family members’ (whose trust has been betrayed) together with their drug misusing relative we can enable them to dialogue about the impact of drugs on all parties. In the spirit of reconciliation and sharing understanding of past hurts, new ways forward could be found.

5. Discrepancies between GPs approaches to lapses could be reduced by having fewer GPs treating drug misusers.

Although most GPs collaborate in their decisions about dosage with drugs workers, some do not, instead basing their decisions on their individual beliefs about what is needed - sometimes without taking into consideration the individual client’s context. With fewer GPs involved there could be more opportunity to develop a shared approach that meets the needs of individuals whilst maintaining a flexible approach.

6. Related to the above: a wider range of medication should be available than methadone alone.
It was clear from our study that many participants’ disliked methadone and wanted more choice. This dislike will inevitably influence outcomes, which currently is poor.

7. Drugs workers and counsellors should be educated to focus on the client’s understanding of their identity development.

Internalised shame created by stigma leads to the client, and those around, him losing sight of the whole person. By enabling clients to identify the impact of destructive life events and societal messages on their sense of self and identity we can help them begin to tell and live out of a preferred sense of who they are and who they want to be.

8. Parenting classes should be offered to enable clients to learn about the needs of their children.

It was clear from our study that clients are concerned about being good parents and in some cases their desire to be a better parent underpinned their decision to quit drugs. In many cases clients have not been adequately parented and therefore do not have the necessary skills. By addressing this need the SP could also help to interrupt the intergenerational patterns evident in the local community.

9. Relationship skills training to build upon the stated need to improve relationships with others.

Many clients turn to drugs when relationships break down. The majority of clients are male. Relationship skills have been recognisably difficult for many men who have not been trained in such matters. Relationship skills with improve their chances of healing intimate and non-intimate relationships as well as enabling the development of empathy.

Further potential research

1. Pursuing the meanings clients attach to becoming ‘clean’:

Whilst carrying out these interviews the many meanings associated with the term ‘clean’ became evident. The term was used when referring to several different states: not using heroin but still using other drugs; only taking methadone; and having withdrawn from methadone (but possibly still smoking cannabis). While we weren’t interested in actual usage patterns in this study it would be beneficial to explore further what clients mean when they profess a desire to ‘get clean’. If there is a mismatch of expectations between client and drug worker when they embark on a treatment programme this will influence outcomes.

2. Exploring gendered topics:

The majority of participants we interviewed were male. We did not seek out specifically gendered topics during interviews, preferring instead to allow the participant to guide which areas they saw as most important. At the end of the relapse prevention group interview, one of the (male) participants stated that there should be more done to attract and accommodate women clients in the project as they had different needs, and ‘have it worse’ than male users (there had been only one female on that relapse prevention group with
five males). Women may be missing out on the benefits that come from sharing their experiences within a group. Further work could explore the reasons for their absence. A predominance of males may alienate females who may wish to attend; there may be different experiences for women than for men that seem impossible to address in a mixed group; and as women are often the carers for small children, lack of childcare could be a factor.

3. More in-depth attention than was possible in this study could be paid to issues related to relapse.

By examining accounts of each lapse separately we might gain further understanding of an individual’s triggers, and what they learn from those experiences when they re-engage with treatment.

4. Explore the influence of the disease concept on how the clients experience their recovery.

Participants and drugs workers referred to drug misuse as ‘a disease’ in their accounts. Berends & Johnston (26) suggest that presenting drug misuse as a disease can risk denying clients meaningful subject-positions in society. Further research is needed to explore how this discourse influences a client’s sense of agency over their recovery and their understanding of relapse.
References

87. McIntosh, J.; McKeganey, N. Addicts' narratives of recovery from drug use: constructing a non-addict identity. Social Science and Medicine, 2000, 50, 1501-1510.
References


APPENDICES
Interview schedule – Methadone Clients

Tell me about your first experiences of drugs.

When did you realize that your use had become a problem?

How did your drug use affect your life?

What made you decide to change?

Why did you come to the Southmead Project?

How did being in treatment affect your life?

What was the most useful part of your treatment?

What was the least useful part of your treatment?

What do you think the Southmead Project should be doing to help you?
Thank you for taking the time to answer this questionnaire. The first part is to give us background information about the range of people who have used the Southmead Project. Then we ask you about your experience of using the methadone programme supported by the Southmead Project. All information is confidential. You can call in to the drop-in centre at the Southmead Project for help in filling in this form, or ring the project administrator on (0117) 9287144 for information about obtaining help.

Age (in years) ……………               Sex – M / F     (Please circle as appropriate)

Marital status - Married / Single / Divorced / Cohabiting / Separated / Widowed

Do you have any children?  YES / NO                                         (circle as appropriate)
If YES please give their ages  (In years)

On what date did you leave the programme?

A. How long were you using drugs before applying to enter the methadone programme?
(years/months)

B. What made you decide to enter the programme?

C. Was this your first treatment with methadone?  YES / NO               (circle as appropriate)
If NO How many previous attempts have you made?

What were the main reasons for your relapse(s)?

D. Are you receiving methadone treatment now?YES / NO                          (circle as appropriate)
If NO, what was the main reason for discontinuing with the treatment? (please tick)
Stayed clean , Red carded , Relapsed but not seeking help
Other reason (please state)
Appendices

E. How did the GP help when you first contacted them about treatment?

F. What else did you need from the GP?

G. What part of your contact with your GP was most helpful to you?

H. What was most unhelpful to you?

I. Did you have any problems during the programme? YES / NO

J. Were there any life events/personal problems that affected your ability to stay on the programme?

K. How many GP’s did you see during treatment?

L. Would you have preferred to see one GP throughout your treatment? YES / NO

M. Have you used any other of the Southmead Project services? YES / NO
**N.** What was the most useful part of your contact with the Southmead Project?

a. Before treatment?

b. During treatment?

c. After treatment?

**O.** Did the Southmead Project provide any support for your family (parents, children, partner etc)?

YES / NO

If YES what was the most useful support they gave them during your treatment?

**P.** Could the Southmead Project provide any additional support to help you?

YES / NO

If YES please state what you would have found helpful -

**Q.** Could the Southmead Project provide any additional support to your family?

YES / NO

If YES please state how they could help?

**R.** Were you in employment at any time during your treatment?

YES / NO

If YES, how did that affect you being on the programme?

**S.** Are you in employment now?

NO

YES / NO

If NO, please give details
Has being on the programme caused any financial problems? YES / NO
If YES please give details -

Please use this space to give any other comments about your experiences on the programme.

If you want to write more please use the page on the reverse of this questionnaire.

Please return the completed questionnaire in the prepaid envelope provided. Thank you for your time.

Additional information

Thank you for providing this information.
Questionnaire – Drug Workers

Thank you for taking the time to answer this questionnaire. All information is confidential. If you have any questions then please contact Emma Barnes (the researcher) by email at Emma.Barnes@bristol.ac.uk, or ring Kate King the project administrator on (0117) 9287144.

1. How is your work setting described? E.g. residential rehab, community project, GP surgery etc.
   …………………………………………………………………………………………………
   …………………………………………………………………………………………………

2. What is your role? E.g. counsellor, prescription management worker etc.
   …………………………………………………………………………………………………
   …………………………………………………………………………………………………

3. Please tell us what qualifications you have, relevant to this role.
   …………………………………………………………………………………………………
   …………………………………………………………………………………………………
   …………………………………………………………………………………………………
   …………………………………………………………………………………………………

4. Please tell us about any previous experience you have of drug issues (personal and/or professional).
   …………………………………………………………………………………………………
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   …………………………………………………………………………………………………

5. How long have you been in your current post?
   …………………………………………………………………………………………………

6. How many clients do you usually see (one-to-one) in one day?
   …………………………………………………………………………………………………

7. How long are the sessions you usually offer?
   …………………………………………………………………………………………………

8. How many one-to-one clients do you usually see in one week?
   …………………………………………………………………………………………………

9. What is your usual caseload?
   …………………………………………………………………………………………………
The next part of the questionnaire deals with questions that help us to clarify if there is a possibility of links between drug dependency and underlying difficulties in childhood such as abuse or trauma.

Definitions: Abuse includes sexual, physical and emotional abuse or neglect. Trauma is defined as events or experiences that cause extreme distress and are outside the child’s control, e.g. loss of a parent, accident, injury or long term separation.

1. Do you think there is a link between a history of abuse/trauma and subsequent drug dependency?

2. If so, why do you think that?

3. What do you normally do if a client discloses abuse/trauma?

4. How many of your current clients have disclosed abuse, e.g. sexual, physical or emotional abuse? (Please give an approximate answer if you do not have exact numbers)
   Men…………………………….. Women………………………………

5. How many current clients have disclosed other forms of childhood trauma? E.g. loss of a parent, accident, long-term separation etc? (Please give an approximate answer if you do not have exact numbers)
   Men …………………………….. Women……………………………...

6. How many of your clients during the past six months have disclosed a history of trauma/abuse? (Please give an approximate answer if you do not have exact numbers)

7. On average, what proportion of your clients at any one time has disclosed a past history of trauma/abuse? ….................................................................

8. What kind of resources can you call upon to support you in this work?

9. What else might you need?
9. What do you think clients that disclose abuse/trauma need?

10. Is there anything else you would like us to know (please continue overleaf if necessary)?

Thank you for providing this information.

If you are willing to meet with a researcher for an interview please put your contact details below or contact the research administrator Kate King 0117- 9287144, kate.king@bristol.ac.uk or Emma Barnes on 0117 9287133/emma.barnes@bristol.ac.uk.

Name (first name will do): ..................... Telephone........................................

Email – .................................................................
Interview schedule – Drug Workers

What made you want to do this job?

What do you see as your role?

What would improve your role? / What would you do differently?

What do you think hinders /helps you in your work?

What model of treatment does your project use?

Do you think that this is the most effective/appropriate model to use?

Do you have any say in the dosage prescribed?

How do you feel about that/how does it affect your relationship with the client?

Would you like to see substitutes other than methadone prescribed?

What do you consider a successful/ unsuccessful detox?

What is the impact on the relationship of maintaining the contract with clients (red card etc)?

What other support do the clients receive (not necessarily treatment related)?

How do you help them to access that support?

How is relapse dealt with?

Are the clients usually ready to seek/accept help?

If not, how does this effect their treatment?

What happens if a client discloses abuse?

What do you think are the main underlying issues that lead to drug abuse?

Have your views changed since you started in this line of work?

Do you receive any supervision/support?

Is there anything else you want us to know?