Crack & Heroin

Day Two

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1. Introduction

.1 How to use this training pack

This pack is intended to be used as a learning tool and also for reference after the training course has been completed. It is not intended for use in isolation to the training course.

Not all the material provided in this pack will be relevant to all services. Much will depend on what services they are offering and the context within which they are provided. The tier structure in which the agency is working and the stage of the user themselves will greatly dictate the material that will be most relevant.

1. Harm reduction

Harm reduction for crack and heroin users is a very new area of work and one that we do not know much about and consequently needs further research and consideration in terms of policy, service development and implication.

There is a wealth of information on the safer injection of heroin and growing evidence regarding crack and cocaine use. Much of this information can be used with crack and heroin users rather than trying to reinvent the wheel. However there are definite differences that need to be taken into account when both drugs are being combined together or crack administered intravenously.

Generally advise users to:

- Don't share injecting or smoking paraphernalia.
- Be aware that when injecting any form of cocaine there will be an anaesthetic effect on the injection site. If you can't feel where the needle is then there is a higher chance that you will miss the vein.
- Vitamin C is the best substance to break the cocaine down into soluble form as it will do less damage if a vein is missed.
- Don't 'skin-pop' as the cocaine can cause blood vessels to constrict (in a localised area) to the point where oxygen is cut off causing major scarring around the injection area.
- Try and eat before using, as it may be some time before they eat again, nutritious health food drinks can be used and will increase vitamin intake. Also advise that users drink plenty of fluids to help avoid dehydration.
- Try and take daily vitamins and minerals to offset the depletion caused by crack and heroin use.
- Use tin foil instead of aluminium foil for pipes if using a 'burner' as this can heat the aluminium to a point where fumes are given off.
- Use with people they trust, in a comfortable environment, as this will lesson the feelings of paranoia and anxiety.
- Always practice safe sex, no matter how big the promised 'rock', 'speedball' seems. Stronger condoms should be used as sex can sometimes go on for a long time.
- Try to buy less, the effect goes down after the first 'hit' so why waste the money.
- Smoking off a glass pipe holds fewer risks than off a home made pipe.
- Be aware of the affects of cocaine use to infected cells and CD4 T-Cells especially if HIV positive.
- Try not to use bigger barrels for 'speedballing' as this may increase the risks of accidental overdose

1.1 Injecting crack or cocaine:

Injecting crack and cocaine is on the increase and mainly seems to be practiced by users who already inject opiates and have established a ritual of injecting. Crack or cocaine may be used as an alternative high, mixed with heroin to produce a 'speedball' or be the main drug of choice.

Crack does not dissolve so well in water so it is added to vitamin C or citric acid (vitamin C seems to be better, although further evidence is required) to break it down to an injectable form. Injecting is not as efficient as smoking crack or cocaine with a high taking about 10-15 seconds to come on. The high is not quite as intense as smoking but then again neither is the come down nor 'crash'.

Dangers:

Site numbness: One of the main dangers is that the user is injecting a local anaesthetic which can lead to a numbing of the injecting site and the inability for the user to feel whether they are in a vein or not. Injecting site rotation after each 'hit' is a possibility but this means that numerous sights would be used throughout the day, as its use is more prolific than that of heroin.

Skin-popping: When you inject crack or cocaine it causes an increase in blood pressure (increased heart rate), which is partly due to the constriction of blood vessels (release of endothelin). When the blood vessels constrict, the blood flow to the injected area is reduced. If the blood flow is reduced sufficiently and for a long enough time the skin tissue dies leaving large wounds and scars.

Septicaemia: Crack and cocaine use badly impairs the immune system through the depletion of essential vitamins and damage to the suppressor 'T cells'. If bacteria are introduced to the blood from either unclean injecting equipment or impure cocaine it can cause an infection, which in turn, with an impaired immune system, can lead to septicaemia. Bacteria can also get into the heart valves, brain, kidneys and lungs, which can all cause complications such as seizures and organ failure.

The dangers of injecting crack and cocaine are many with increased risk of abscesses, thrombosis and vein damage as well as most of the risks associated with smoking crack or cocaine. Because of the increased risk taking behaviour and strong compulsive nature of the drug there is also an increased risk of using 'dirty works' which in turn can lead to the contraction of the HIV or Hepatitis virus.

Harm reduction:

Safe injecting practices are more or less the same as for injecting opiates, clean needles, clean injecting area etc., although advice and information should also include safe, clean and effective methods for preparing crack cocaine for injectable use. However be prepared for all this information to be ignored when the compulsion to use takes hold. The bottom line for safer injecting is <u>not</u> to inject, but this is always down to client choice.

Speedballing:

The combination of crack / cocaine and heroin can be very attractive as the 'comedown' crash experienced when crack or cocaine is used on its own can be averted by the effects of heroin. However, speedballing is also associated with the dangers of injecting crack, as well as injecting in general, eg. contaminants, overdose.

Dangers occur with this combination because of the combination:

- Neurologists have found that when combined heroin can increase the potency of cocaine and visa versa by acting on the cocaine mu agonists and increasing its capacity as a reinforcer.
- Heroin lowers respiration rates and in high doses so can cocaine, leading to dangers of respiratory failure.

- Opiates can lower the threshold for brain seizures and cocaine can cause brain seizures.
- The affects of cocaine can interfere with the user's ability to judge how much heroin they have really had, increasing the potential for accidental overdose. Amounts of each drug should be lowered when used in combination. Because of cocaine's initial effects on the cardiovascular system it is unlikely that overdoses will occur immediately after injection as with normal heroin overdoses.

1.2 Crack Pipes:

Most of the crack pipes made in Britain are self manufactured (some very hastily) and can have detrimental effects upon the health of the user. Typical pipes used for smoking crack include:

Tin can, water bottle pipe, drinking glass pipe, glass pipe and metal pipe.

Most people use lighters to heat the crack but some use a burner, using a burner on some pipes can add to the risks. Obviously smoking crack cocaine itself carries health risks but the type of pipe used can either increase or decrease these risks.

Dangers:

- Tin can – Burning paint fumes inhaled and cuts to mouth on can. Not burner friendly.
- Water bottle pipe – Plastic fumes (dioxins), water vapour inhalation. Not burner friendly.
- Drinking glass pipe – Burns to the lips, glass can crack under heat, water vapour inhalation, fumes from foil. Not burner friendly.
- Glass pipe – if not made of heat resistant glass then could explode if used with burner, burns to fingers if not insulated. Burner friendly if proper glass.
- Metal pipe – Burns to fingers if not insulated properly. Burner friendly.

Generally the risks go down the better the pipe is.

Advice to users:

- Burns caused to fingers and lips often produce open weeping wounds that can pass on Hep C and HIV – Don't share, always use your own pipe.
- Dehydration can cause the mouth area to become chapped and again produce weeping wounds – Drink plenty of water and use Vaseline / lip salve to keep from drying out.
- Ash used as a filter can often be drawn into the lungs again causing damage – Always use a metal gauze to prevent this from happening.
- Cheaper glass pipes can explode or crack if heated with a burner – Either use with a lighter or get a toughened glass pipe / use a metal one.
- If Epileptic always use a lighter rather than a burner – Lighters go out if you drop them when having a fit.
- Smoke off a toughened glass or metal pipe – This will help reduce the risks associated with smoking crack cocaine. NB Advise users to be careful of carrying pipes around as it could complicate matters if arrested.
- Change metal gauzes often – this is to help prevent the gauzes from becoming fragile and the user inhaling the small bits that may break off.

Warning: Always check with your organisation before giving this information out to clients

2. Attracting users to services

Services need to be very clear about the clients they are seeking to attract. This information should come from local needs' assessments (*Commissioning cocaine/crack treatment*, NTA 2002).

For example, if the needs assessment has established that some misusers are injecting both crack and heroin, then it is vitally important to have good working relationships with harm reduction and needle exchange services, detoxification services and prescribing services, to increase accessibility and knowledge. Both generic drug misuse services and those targeting crack users should work together on issues to improve access and reduce the risks of current opiate clients destabilising due to crack misuse. This will impact upon the standard of service provided and the reputation of the project amongst users.

Many projects will already be attracting heroin users who have started to use crack into their services but it does not mean that these clients are being appropriately worked with or that full information is being shared regarding the combined use. Many heroin users will only see services as being able to work with their opiate use and will therefore minimise their crack use or not fully understand the impact it may be having on them. With this in mind the same processes of attracting primary crack users into services should be utilised to increase referrals from crack and heroin users whether they are in contact with services or not.

Developing links with other services

It is important that all services know about the project so that working relationships can be improved, partnerships can be established and agencies can advertise each others' services. This should be encouraged by commissioners and occur in the context of implementation of *Models of care*. Establishing links with the criminal justice system is important, but this should be balanced with the need to attract users who may be deterred by the image that the service is primarily for offenders. Community services, local pubs/clubs can also be integral in establishing links with users who may not have had contact with drug services before.

Waiting times:

A high proportion of crack and heroin users that are referring themselves to services can be in crisis. This means that agencies need to respond quickly to clients if they want to increase engagement and retention and where possible avoid waiting times of a week or more. Developing quick response times may also mean that agencies will need to look at existing appointment protocol and case loads.

Accessing marginalised groups

Services will need to consider strategies for accessing marginalised groups like sex workers and refugees as well as developing strong links with non-statutory agencies working with Black and ethnic minority groups, young people etc.

User consultation

In trying to attract users to services it is imperative that services actually talk to and consultant users and carers themselves. They can help to build a service that is attractive and effective. They can also help spread the word about the service. User consultation should be a regular part of service evaluation so that agencies can respond quickly to changes in client group and drug trends.

Physical environment

Agencies will need to carefully consider both the location and design of the premises that they use to provide services to crack and heroin users. The emphasis should be on creating a relaxed, non-threatening environment. This should include careful planning of opening times to maximise client contact.

Letting users know

Agencies need to advertise their services in order to let users know they exist. This can be done on a variety of levels and needs to take into account that the client group can be mistrusting, new to services and have little faith about the service to begin with. Some of the different methods that have previously been used to attract users to services include:

- *Discreet services* - Having a large shop banner over the project or basing the service within official buildings can deter users.

- *Posters* - These can be useful and displayed in a variety of locations. Telephone numbers should be printed large enough so that users do not have to examine the poster too closely.

- *Project information* - Develop the agency's advice and information services. This will demonstrate and understanding of crack and cocaine and help increase trust in the service.

- *Radio* - Local or community radio stations are usually open to advertising the service on offer and can dramatically increase the number of users, family and friends who hear about the services.

- *Lighters* - Lighters can be an effective method of reaching users who are not in contact with services as they are usually appropriated several times and can reach a number of users, not just one.

- *Staff team* - If the agency is trying to attract women and users from Black and minority ethnic communities, then the staff team needs to reflect this and enable users to feel comfortable with initial engagement.

- *Specific services* - If the agency claims to offer a crack and heroin service, ensure that it is provided, otherwise retention rates will decrease.

- *Outreach* - Specialist outreach and peripatetic teams can help to engage with the using community and increase awareness amongst users.

Some open access services have found that the best way to attract users into a service is by 'word of mouth' and this is dependent upon the service that it provides. If the service is good and it delivers, then this will be reflected in the agency's reputation. Make sure that the service delivers what it says it is going to deliver. Develop regular user consultation and listen to what is being said.

3. Referral and assessment

Referral and assessment procedures assist in gaining information, engaging users and developing initial care plans and pathways. The questions asked provide the agency with important information and can also be used as opportunities to discuss issues that might increase the prospects of engagement and increase client participation (*QuADS: Professional Competencies*, 2000).

6.1 Levels of assessment

All assessment processes should be in line with the recommendations in *Models of care*, QuADS and crack/cocaine service specifications, and developed as part of the local drug treatment system.

Models of care outlines three levels of assessment:

Level 1 Screening and referral assessment (tier 1 and 4b services)
Level 2 Drug and alcohol misuse triage assessment (tier 2, 3 and 4 services)
Level 3 Comprehensive drug and alcohol misuse assessment (tier 3 and 4a and some tier 2 services)

Assessment should be an ongoing process, rather than a one-off event, as an individual's needs are likely to evolve over time. Review and reassessment at regular intervals are necessary for good care planning and co-ordination. Different levels of assessment require different levels of competency (see Diagram 2: The assessment system).

The following guidelines offer some advice on how these recommendations can become more crack and heroin specific and increase the likelihood of engagement and retention.

- **Ensure that assessment forms take into account crack use and 'speedballing'.** Many assessment forms have become biased towards opiate use and the dominant trends of a few years ago. It is important that all agencies review there assessment forms and procedures in light of crack and heroin use and include areas that will gather vital information.

- **Agencies should be prepared for clients miss appointments or to turn up late.** Always have other work on hand so that the time is not wasted. A phone call or text message (if permission has been given) the day before the assessment can increase attendance rates and also give the worker opportunity to assess the current situation.

- **If a client does not attend assessments**, some services have found it beneficial to phone, text or write to see if the client is still interested. It may be advisable to leave a gap of a few weeks after the first letter / phone call and then send another letter.

.2 Level 1: Screening, referral, assessment and issues for crack and cocaine misusers

Referral and assessment should not just be about the service getting to know the client, but also giving the client the opportunity to get to know the service. The initial contact with the client is critical in terms of establishing a level of trust and confidence that will help ensure that they come back again. Crack and heroin users can often present in a state of crisis and reassurance and affirmation that they have taken an important and courageous step in seeking help may be more important than completing assessment forms at this stage.

The initial contact with the client offers the opportunity to maximise engagement by:

- Asking a client about their drug use can provide the opportunity to discuss harm reduction interventions.
- Asking about specific physical and mental health issues can help to identify problems that need immediate attention.
- Asking about suitable assessment times can increase the chances of clients accessing services.
    - A morning appointment is probably unsuitable for a client who has finished using at 6.00 am.

- An afternoon appointment is probably unsuitable for a client who supports their habit by shoplifting and starts shoplifting in the afternoon.

Users should be seen quickly as they are often in crisis when approaching a service (*National Crack Cocaine Treatment and Response Strategy*, 2000). Early treatment should be more intensive in order to enable adequate crisis intervention work.

The referral and assessment processes need to be user-friendly so that the engagement process can be a positive one. If clients' initial experience of a service is positive, this will be relayed to other users and the reputation of the service will improve.

The referral is the very first point of contact with an agency, so adequate time needs to be allocated to it. Agencies should allow adequate time per referral and calculate this in staffing levels.

An initial contact and referral could include the following:

- Suggest phoning the client back in order to save them money
- Explain the type of services provided
- Explain what processes the client may have to go through
- Ask if the client understands how crack and heroin work. If levels of understanding are low, provide some basic information of the effects. This will demonstrate that the agency is knowledgeable about crack/cocaine
- Explain confidentiality and the agency's confidentiality policy
- Ask for their consent to take some basic details and outline what will be asked
- Conduct initial referral assessment using the questions as an opportunity to provide harm reduction/relapse management advice and increase the chances of engagement
- Ask for their consent to phone them on the telephone number they provided. Ask if it is safe to do this.
- Explain what the assessment process will involve
- Give them an appointment date and time (as soon as possible)
- Inform them of other effective services (additional support). A named worker can help with this process
- Explain how to re-book an assessment if they miss the appointment
- Ask them if they require any further information or support
- If possible, post information on the agency's services and on crack cocaine to the client
- If the client is extremely mistrustful of the service and refuses to give any details, explore ways to set up a visit or talk to help reduce fears.

6.3 Level 2: Drug and alcohol misuse triage assessment (tier 2, 3 and 4 services) and Level 3: Comprehensive drug (and alcohol) misuse assessment

The following may be included in an initial assessment:

- Explain the agency's confidentiality policy and exactly what this means. This may have been explained at referral, but it should be clarified.

- Explain how crack and cocaine works, why clients may experience anxiety, depression and paranoia. This often helps to answer questions and builds trust in the agency.

- Describe the services on offer and how these can be of benefit to the client. For example, the benefits of complementary therapies become clearer once the client understands the fight or flight response.

- If appropriate, conduct initial assessment. Use opportunities to give further information and identify initial relapse management strategies.

- Again ask for consent to contact them if they lose contact with the agency or miss subsequent appointments. Further contact details may be gathered.

- Offer acupuncture, complementary therapies or breathing exercises to help relax the client as talking about cocaine may have triggered a craving

- Inform client of other services available if required (rehab, day programme etc) and talk about the process and what it might entail

- Give client good written information on crack and heroin, there combination and service (if not already done so)

- Inform the client what will happen next. If referring for funding assessment etc, ask for consent to pass on the information that they have provided and complete consent forms.

- Start to develop support networks and initial care plan/relapse management strategies and agree with the client on a course of action

Some clients may be too paranoid or mistrustful to undergo any form of assessment. In these cases in is very important to proceed slowly. This may mean that there is little information obtained from the client for several visits.

In line with *Models of care*, all services should develop common assessment tools across the area. Clients should be involved in the development of these tools and procedures. Screening and assessment tools and procedures need to strike a careful balance between meeting the needs of the service and not discouraging the client.

In addition to the elements described in *Models of care*, an assessment that adequately addressed the needs of crack and cocaine users would need to consider the following issues:

- The assessment needs to be able to identify the context of the users crack / heroin consumption in their overall pattern of use. Whether crack or heroin is the primary or secondary drug or whether it is part of a more complex pattern of polydrug and alcohol use. There needs to be an awareness that some drug users will highlight their opiate use because they feel that this aspect of their drug use is more likely to be perceived as "treatable".

- Symptoms of mental health disorders like anxiety, depression, paranoia and psychosis are often associated with crack use and in some instances the use of crack and cocaine can mask symptoms of underling mental illness. There is also some evidence that the stimulant users are a high-risk group in relation to suicide.

- In view of the complex and wide ranging needs that can be associated with crack and cocaine use, a multi-disciplinary approach to assessment is essential.

- There are many stereotypes and assumptions made regarding crack and heroin use and the black and minority ethnic community / links with the sex work industry and it is important that staff undertaking assessments are sensitive to the cultural and gender issues that may be present.

- There are now a range of assessment and monitoring tools available but staff need to be aware that many of these have been designed primarily with the needs of opiate users in mind. Crack users can respond to treatment (both positively and negatively) more rapidly than opiate users and may therefore need to be monitored more frequently.

6.4 Ongoing monitoring

Crack and heroin users can move very quickly between various stages of recovery and it is important that indicators, like responses to triggers/cravings, physical and mental health are carefully monitored in order to assess their vulnerability to lapse and relapse and respond accordingly.

Having established a detailed picture of the users pattern of crack and cocaine use and their offending behaviour profile at the initial assessment stage, a process of regular monitoring and review needs to be built into their care package. Where possible this review should take place on a weekly basis to accommodate the speed of change that can occur when working with crack and cocaine users.

The cocaine monitoring form can be used for this purpose and will allow the client and worker to see progression on a weekly basis.

4. Treatment stages

The following processes outlined below give a guide to how crack and heroin users can be worked with at different stages. These are based in the experience and evidence that we have so far in working with crack and cocaine users. Each stage will be dealt with in more detail over the next few chapters.

Stage	Tier	Process	Treatment tools
Stage 1: • New user • Established (non chaotic) user • Problematic (chaotic) user	Tier 2	**Use Management** This process allows for both brain and body chemistry to re-balance and reduce the chaos sometimes associated with problematic crack use and establish prescription / detoxification options	• Harm reduction for crack and heroin users • Patterns of use • Assessment form • Care plan form • BBV risk assessment • Crack / heroin / methadone monitoring form
Stage 2: • Stabilised use • Recently stopped	Tiers 3 & 4	**Relapse Prevention** Once use has either reduced / stabilised more intensive work can now be undertaken.	• Care plan form • Triggers chart • Crack and heroin triggers • Dangerous situations • Cravings • Euphoric recall
Stage 3: • Recent lapse / extended lapse	Tiers 2, 3 & 4	**Lapse Management** Lapses can be worked with very quickly. However it is vitally important that users understand what led them to lapse.	• Learning from lapses
Stage 4: • Full relapse	Tier 2	**Use Management** This stage usually follows the same process as stage 1 because use has now returned to previous levels or become worse.	• Harm reduction for crack and heroin users • Patterns of use • Assessment form • Care plan form • BBV risk assessment • Crack / heroin / methadone monitoring form
Stage 5: • Extended period of abstinence • Recently completed treatment	Tiers 3 & 4	**Life Management** This stage should focus upon developing support networks that are independent of drug services but allow for support when needed.	

5. Treatment stage 1 (Use Management)

Use management is a way of working with clients that have recently presented themselves to your service or have disclosed that their crack and heroin use has become problematic.

Physical and mental health issues:
Physical: May have heart & lung problems, weight loss, poor immune system, major problems due to injection, BBV's and general physical issues associated with crack and heroin use.
Mental**:** Anxiety, paranoia, depression, possible psychosis and mood problems.
Health assessments are strongly advised especially if there are any concerns regarding either physical or mental health needs.

Process:
Use Management: Specific information on how crack and heroin works, health, harm reduction techniques etc. Practical approach based around information and help that can assist users to stabilise or stop crack and heroin use altogether or to stabilise use. Agencies will also need to work with other drugs that are being used in conjunction with crack and heroin such as tranquilisers, alcohol, methadone etc.

Interventions:
- Complimentary therapies
- Advice and information
- Solution Focused Therapy
- Motivational Interviewing
- Legal advice
- Health care / check ups
- Advocacy work
- Work with poly drug use

Treatment tools (see appendices):
- Harm reduction for crack and heroin users
- Cocaine monitoring form
- Patterns of use
- Assessment form
- Care plan form
- BBV risk assessment (cocaine)
- Crack / heroin / methadone monitoring form

Aims:
- Stabilise / stop use.
- Reduce associated harm.
- Improve physical / mental health.
- Develop self-esteem.
- Education and knowledge.
- User empowerment.

5.1 Crack and heroin use management:
Concentrate upon strategies to help clients keep safe and avoid situations that may lead to use. Make these realistic, practical and achievable. Enabling a client to understand their patterns of use can form a starting point for treatment / understanding. The patterns of use handout can be utilised and strategies developed that are pertinent to user such as:

- Carry envelopes with name, address and stamp. Too much money? Starting to crave? Post it to yourself. You get the money in the morning or next day and have time to think what to do with it.
- Avoid people, places and faces. Work out routes that take you safely past areas or that don't have associations.
- Understand the danger of scoring heroin as many dealers are now pushing more than one

drug and this may lead back to crack use
- Carry relaxing oils. Sniff in times of crisis.
- Don't carry more than £5, £10, £15 what ever amount triggers you off with either crack or heroin.
- Inform people (safely) that you don't use anymore. Don't leave doors open.
- Get rid of all paraphernalia once you have stopped using (and don't go shopping the next day to buy foil, bottles of water, and a packet of Blue tack to put the new posters up with!).
- Plan ahead. See if dangerous situations can be identified.
- Plan support for dangerous situations.
- Always have a plan 'B'. Where can I run to when I need to be safe?
- Build alternative support networks, NA, college, clean friends, hobbies etc.
- Use alternative therapies/breathing exercises to help reduce craving.

The above strategies need to be dispersed over various sessions to help clients gradually move into the relapse prevention or 'active change' stage. Respond to the clients needs (as they identify them) helping them to reduce consumption, physically and emotionally feel better and become clearer of longer-term achievable goals.

Other possibilities may include holding payment books if the dealer usually holds them (this would have to be discussed with your project managers and proper systems put in place). Get clients to change the Post Office to one near the agency so that you can support them in cashing the book / Giro.

Some clients may not want to stop their use of crack and heroin altogether or at this particular point in time. Harm reduction / controlled use strategies can be employed to help users achieve this.

Challenge irrational behaviour with the client, look at where this is coming from (refer back to changes in brain chemistry). Why use £200 of crack when you will get to the same point with £100 or £50. Explain how the reward and reinforcement system is creating compulsive behaviour. Ask them what rational behaviour would be in the same situation? Or if you were the client and they were the worker, what would they advise?

Take things step by step and develop achievable goals that will encourage a client's belief in themselves, build self esteem and confidence.

Use auricular acupuncture / other complimentary therapies alongside these sessions to help both with relaxing a client and also in dealing with cravings that may have been sparked off.

Remember to look at support networks that will help them, use time and develop self-esteem / direction in life (college, NA/CA, local gym, hobbies, enjoyable activities as well as structured programmes).

The time span of this stage will vary greatly from client to client and may last as little as a week or two and as long as a year depending on circumstances, motivation, support etc.

5.2 Crack and Heroin: If crack or cocaine are being injected then advice on safe injecting practice and dangers of use need to be given. If crack or cocaine are being used together in a 'speedball' then again clients need to be informed of the dangers of use. Clients may regard Heroin to be the primary drug of choice yet are spending much more on crack. Get the client to look at their patterns of use, risk-taking behaviour, cost of both habits etc. They will often need to be worked with in conjunction with each other but if they see the crack or cocaine use as just a secondary habit that is not really important they will probably find trying to stop very difficult.

Gaining a detox place / script may be another potential problem as waiting lists can be long. If the client has come to the service because they are in crisis with crack, the heroin addiction will also need to be worked with. This is because most dealers now are selling both drugs, so if the doors are left open for one then the temptation / pressure to use the other will be that much stronger.

5.3 Poly drug use:
Crack and cocaine are often used in conjunction with other drugs. Because the use of both drugs used become associated with each other it is important to look at how these combinations can spark each other off and the particular dangers / peculiarities associated.

Once you have ascertained a clients using pattern, what drugs they use and how you need to be able to discuss with them how this could affect them trying to stop. Below are some of the combinations that you will come across and some of the issue that you may need to raise with the client.

Crack / Heroin and Alcohol: Cocaethylene has an effect on the pleasure giving neurotransmitters which produces a high very similar to that of crack and cocaine. Users who combine these two substances together will probably find it very hard to use even small amounts of alcohol and not crave for crack or cocaine, because of the body's anticipation of receiving cocaethylene. It would be advisable that if a client uses in this way that they steer clear of alcohol as well as crack for some time. Clients may also have developed a bigger alcohol problem than they were aware of and may need a detox.

Crack / Heroin and Cannabis: As a come down drug cannabis may be less harmful than alcohol and may not cause the client any real problems. Ask them if they score their cannabis from their crack dealer or nearby as this could lead to a lapse:

If they combine crack and cannabis together in a spliff then smoking cannabis may bring on strong cravings because of the association and similar paraphernalia. Some forms of skunk have also had crack mixed with it at the point of sale so be careful that clients don't get caught unawares.

Crack / Heroin and Benzodiazepines: The main issue with benzodiazepine use is regarding the levels used, how frequently and for how long. A client may not be aware that they need to come down gradually from the benzo's. Proper medical advice will need to be sought to develop an appropriate reduction plan. Detoxification from benzo's can also produce feelings of anxiety / depression which can trigger the user in to thinking that they need crack or are experiencing a craving.

Other combinations that you may come across include:

- Crack / Heroin and Amphetamines
- Cocaine and Ketamine (may be increased potential for psychosis)
- Cocaine and Ecstasy (may be increased potential for hyperthermia in clubbing environments)
- Crack and household air freshener (damage to kidney's and liver, possible carcinogen)
- Cocaine and Viagra (increases likelihood of cardiovascular problems)

Clients may be reluctant to give up all drug use and the need to do this will depend upon treatment stage and programme philosophy. However it is vitally important that they understand potential risks and triggers associated with combination use.

Workers also need to be aware that the above combinations can themselves be combined so that you can get Crack – Heroin – Tranquilisers – Alcohol – Cannabis – Methadone mix.

6. Treatment stage 2 (Relapse Prevention)

Once clients have reached a point where they have been able to stop using or have greatly reduced the amount used they need to be able to keep the process going. The combination of knowledge of use and development of life through personal goals and support networks will go some way to helping them achieve this.

Physical and mental health issues:
Physical: Health should be improving if no major issues (unless related to BBV's, serious injecting complications and serious cardiovascular / pulmonary problems), particularly if stopped using.
Mental: Symptoms of anxiety and paranoia may still be present. Depression should be improving if only solely to do with neurotransmitter depletion.

Process:
Relapse Prevention: More detailed information on how to maintain abstinence. Look at rational / irrational behaviour, triggers, cravings, patterns associated with crack and heroin use and alternatives to drug use. Group or individual working practices can be employed well at this stage.

Interventions:

- Complimentary therapies
- Group / individual work
- Life skills
- Relapse prevention
- Goal setting and planning
- Low key therapeutic support

Treatment tools (see appendices):

- Care plan form
- Triggers chart
- Crack and heroin triggers
- Dangerous situations
- Cravings
- Euphoric recall

Aims:

- Maintain abstinence / stabilisation
- Understanding of own use.
- Improve physical / mental health.
- Develop confidence / assertion.
- Practice learnt skills.
- Set / reach achievable goals.

9.1 Crack and heroin relapse prevention:
Developing strategies that will help clients maintain stabilisation or abstinence is one of the priorities at this stage. Once clients have stopped using for a short while crack and heroin users can feel that they have recovered quickly (especially if they have undergone a detox for heroin), this can lead to them dropping defences and becoming more vulnerable to lapses and relapse / minimising their crack problem.

In order to help prevent this happening clients need to develop long-term strategies in a number of areas.

Avoidance: Clients may be tempted to return to old places, friendships, acquaintances or habits because they feel strong enough / isolated / emotional. This can put them in extremely vulnerable situations and lead to lapses. Cue exposure may be of value in relation to these issues, but proper guidance must be sought in relation to this subject.

Relaxation: The more relaxed clients become the less that they are likely to crave. Relaxation techniques also provide practical solutions to coping with craving or potential trigger situations.

Support Networks: Support can come from many areas, not just from a drugs agency. College, religion, family, non-using friends, hobbies, employment can all offer different types of support.

Health: Using crack and heroin will have had some effect upon clients health. Keeping healthy through exercise, eating well, vitamins, meditation etc, will help clients to feel better and also counteract high adrenalin levels, impaired immune system and general poor health. Good health checks are advised.

Leisure: If treatment feels like its all hard work then clients could be set up for a lapse. Help clients to develop things in your life that give enjoyment, something that they can look forward to.

Practical Issues: Clients may have built up debt, housing problems; feel isolated and become involved with the criminal justice system. Practical help and support may need to be offered in dealing with these issues.

9.2 Group / individual work:
Once you have enabled a client to move from **use management** to **relapse prevention** the stability of the client should enable you to work in a more structured and detailed way and generally clients will want to do this.

More detailed information needs to be given regarding the patterns of use, understanding of the drug, and how to maintain abstinence from crack and cocaine.

The following list gives a basic foundation on which you can build an individual or group work package:

- **Health:** Begin to educate clients regarding the health risks associated with crack and heroin use. The knowledge of health issues amongst users is usually very poor, especially with clients who 'snort' cocaine hydrochloride.

- **Triggers:** It is important for a client to understand how triggers work, how this links in with the 'fight and flight' response, craving / use of both drugs and what their main triggers are. Users can often use the same set of triggers over and over again unless awareness is gained.

- **Cravings:** Triggers usually lead on to cravings, so again it is important for users to understand what they are, the types of craving and what to do when cravings start. Users often feel powerless with craving (especially with physical cravings from heroin) and knowledge can change their perception of power.

- **Cycles of use:** Again this gives further understanding into the personal mechanics of crack and heroin use. Using treatment tools to find out these patterns coupled with the Cycle of Change can be a very powerful combination and help clients understand where they are and where they need to go.

- **Euphoric recall:** This gives understanding of how personal actions can lead to so called 'cravings out of the blue' and will also prepare the client for when this happens. Challenge the justifications to use and begin to develop strategies to cope with them.

- **Prevention Strategies:** This helps to underline the areas that need to be strengthened and continue to be guarded. It will also help a client to identify the areas that they need support in to keep their lives going in the direction they want.

Please see appendices for treatment tools relating to the above.

These sessions can be accompanied by life skills sessions that help the client look at other important factors in their lifestyle. Once they have gained an understanding of how crack and heroin work then certain life skills can become valuable tools:

- **Anxiety Management** Further understanding of triggers and cravings
- **Self Esteem** Helps counteract low dopamine levels
- **Assertion Training** Builds confidence in certain situations
- **Positive Thinking** Image building, counteracts low self worth
- **Confidence Building** Helps prepare for college, work etc

Also remember to work with clients on issues that help build up their life and support networks (drug use is never an isolated problem). Everybody is an individual, with different interests, beliefs and problems so there can be no set plan to this, but might include the following areas.

- Practical issues
- Religious beliefs
- Emotional issues
- Employment
- Relationship issues
- Health issues
- Cultural issues
- Sexuality issues

Encourage clients to develop strategies and understanding around their dependence on crack and heroin so that they develop the skills to keep themselves on their path.

7. Treatment stage 3 (Lapse Management)

The process of relapse management is important in all Tiers of treatment, but probably has the most relevance in the initial stages of treatment (unless operating a Tier 3 and 4 service that works with crisis intervention). Because of the chaotic nature of most crack and cocaine users when first presenting to services, it is vitally important to manage relapse.

The process of relapse with crack and heroin use is often that when they relapse on one they will lapse on the other it is therefore vitally important to have done work around this issue previously so that the potential for this can be reduced.

Physical and mental health issues:
If a short lapse then the physical and mental health issues may be low. However if client has gone through an extended lapse then health problems could be much more severe as with stage 1. Physical addiction to heroin will not have been built up with a one off occasion, although the dangers of overdose because of reduced tolerance are ever present and work should be undertaken with this in mind once the user has stabilised or come off completely.

Physical: Aches and pains, dehydration, insomnia, injection site problems and physical tiredness.
Mental: Anxiety and paranoia may have returned, strong feelings of guilt and depression may also be apparent.

Process:
Lapse management: A combination of stage 1 & 2. Examine lapse with client so that they can learn from mistakes made and strengthen relapse prevention strategies / spot danger points from mistakes made.

Interventions:
- Complimentary therapies
- Solution Focused Therapy
- Motivational Interviewing
- Self esteem work
- Challenge justifications & denial
- Make it a learning process

Treatment tools (see appendices):

- Patterns of use
- Learning from lapses
- Care plan form

Aims:
- Re-focus client
- Learn from mistakes
- Awareness of justifications
- Prevent lapse turning into full relapse
- Strengthen prevention strategies
- Get back on course

The process of lapse and relapse can sometimes be difficult to quantify so for the purpose of this training pack the following definitions shall apply:

Abstained: Clients who, once they entered into treatment, do not use crack or heroin again (they can be on prescribed methadone scripts).

Lapse: Clients who may experience short term (1 - 10 days) return(s) to use of crack or heroin, followed by longer periods of abstinence.

Extended lapse: Clients who experience an extended period of use (2 - 12 weeks) but have maintained contact with treatment services and follow this use with long periods of abstinence (tolerance to heroin will have been built up again at this stage so detoxification may be necessary).

Full relapse: Clients who experience a full return to drug use after a period of treatment and are choosing not to engage in services on offer.

10.1 Lapse management

It is important that lapses are worked with quickly and effectively so that a short using episode does not turn into a full relapse and prohibit continued engagement in Tier 3 & 4 treatment. Staff should be aware of the impact that feelings of guilt and a sense of failure can have on the client's response and be able to work with this.

It is likely that lapses will occur more frequently in community based services (and be easier to work with) than residential, however lapses do occur within residential settings and need to be worked with in a constructive manner.

A lapse does not mean that clients have gone back to square one. If they feel totally negative about the incident then they may miss the opportunity to learn from mistakes and may make the same mistake again.

Clients need to understand:

- **What happened?**
- **How it happened?**
- **How can they stop it happening again?**

Start by tracing the events that led to them using. They may need to go over things a few times going one step further back to trace the initial set up. Look at who they were with? How did they feel emotionally / physically? Where did they get the money from? What justifications were used?

In some cases it may feel best that they go home and sleep it off and then come back to the project when they are feeling better. This may put them in a more vulnerable position and possibly lead to an extended or full relapse so try to work with lapses as quickly as possible. Complimentary therapies can help the recovery process at initial stage.

Be aware of the clients emotional state and that this too could also lead to further use. It is important that the client understands that the lapse is not a return to square one and can be used as a positive learning experience.

10.2 Extended lapse management

Some lapses will extend past a few days use and can either move into a full relapse or, on occasions, develop into an extended lapse. Although use may be chaotic again, the willingness to continue treatment is what differentiates this from a full relapse. Tier 4 services will probably be unable to work with extended lapses due to the longer time period, however this is where movement between tiers is essential so that clients can continue treatment at an appropriate level. Tier 2 services are probably best placed to work with this type of lapse and certain tier 3 services may find it possible.

8. Treatment stage 4 (Use Management)

Stage 4 is more or less the same process as stage 1 except that the client has had previous experience of the project and treatment and has therefore hopefully built up a level of trust and knowledge. This allows agencies to engage users into treatment a lot quicker and also utilise their previous experience in looking at how a lapse turned into a full relapse (see stage 3).

Physical and mental health issues:
Physical: May have heart & lung problems, weight loss, poor immune system, major problems due to injection, BBV's and general physical issues associated with crack and heroin use.
Mental**:** Anxiety, paranoia, depression, possible psychosis and mood problems.
Health assessments are strongly advised especially if there are any concerns regarding either physical or mental health needs.

Process:
Use Management: As with stage 1 but clients should be able to link in with previous knowledge / experience.

Interventions:
- Complimentary therapies
- Advice and information
- Solution Focused Therapy
- Motivational Interviewing
- Legal advice
- Health care / check ups
- Advocacy work
- Work with poly drug use

Treatment tools (see appendices):
- Harm reduction for crack and heroin users
- Cocaine monitoring form
- Patterns of use
- Assessment form
- Care plan form
- Learning from lapses
- BBV risk assessment (cocaine)
- Crack / heroin / methadone monitoring form

Aims:
- Stabilise / stop use.
- Reduce associated harm.
- Improve physical / mental health.
- Develop self-esteem.
- Education and knowledge.
- User empowerment.

If a client has not had experience of your project before but has had treatment then find out the level of knowledge that they do have so that this can be built upon.

9. Treatment stage 5 (Life Management)

Life management is as the name suggests. The client has reached a point where they have abstained from or stabilised their use of crack and heroin for a sufficient period of time to start to focus their attention upon their lives rather than their problematic use of drugs. This does not mean that prevention strategies are forgotten more that the emphasis has changed from the main issue being problematic drug use to building up their life.

Physical and mental health issues:
Physical and mental health problems should be very low if there was no serious / permanent damage done during their use. However some clients may still have issues with anxiety especially in relation to college / work etc.

Process:
Life Management: Clients should be practising prevention strategies, building up their life and replacing use with elements they want in their life such as support networks, college, work etc. Crack users have generally last been in employment a short while before treatment (average 9 months in City Roads Study) whereas heroin users may have a much longer time period from their last employment. Crack and heroin users may fit into one or the other depending which dependence came first.

Interventions:
- Complimentary therapies
- Specific counselling if needed
- Support groups
- Alternative social networks
- Long term prescription maintenance
- After care groups

Treatment tools (see appendices):
- Care plan form

Aims:
- Maintain abstinence / stabilisation
- Build support networks
- Develop social networks
- Keeping focused
- Building life

12.1 Life management
Management strategies are there to support the work that they have previously achieved rather than replace. It is a time of movement where the client will be either decreasing or ending their contact with the specific drug service. Consequently it is a very important phase.

The client should have:

- **Developed an understanding of crack and heroin**
- **Developed a personal awareness of there own patterns of use**
- **Developed an understanding of the ways to counteract triggers, cravings etc**
- **Developed personal strategies regarding how they can cope**
- **Developed an understanding of other factors involved**
- **Developed an awareness of issues that need to be addressed**

The focus of attention now needs to be looking at the further development of support networks, alternative social networks and specific therapeutic treatment, if needed.

Support Networks: Clients will probably need to develop a balance between general support and support specifically tailored to ex-users. College, religion, employment, CA / NA can all give valuable support in this area.

Social Networks: Old non-using networks may have been re-established, but new ones also need to be developed. Clubs, hobbies / interests and gym's are all ways of developing new networks.

Therapeutic Treatment: Some users may have long term issues that they wish to address. These may have been present before they started to use or were developed during their use. Either way at this point the client should be in a strong enough position to start this process. It is also a stage where long term counselling can be offered by professional counsellors in a related fields (bereavement, sexual abuse etc) and not be dictated to by staffing levels, caseloads and finance as is so often the case in the drugs field.

Because the focus of attention is now changing, it is vitally important to underline the need for continued awareness regarding triggers, cravings and set ups. Because of the psychological addictive nature of crack and cocaine, cravings may appear seemingly 'out of the blue' and a long way done the line. With this in mind it is advisable to develop long term after care facilities to help support clients if this does happen.

12.2 After Care

If agencies are looking to provide Tier 3 and 4 services, then the issue of aftercare needs to be addressed. This can be a very effective form of treatment for users who have completed programmes and need some form of optional continued support.

Aftercare may be thought of as a short period of time of reduced care following an intensive course of treatment. Aftercare can, however, encompass a range of support for a longer period of time to enable a client to reintegrate into society. Clients also need quick access to a service if they have a lapse, irrespective of how long ago they left treatment. Clients need to be reassured that they do not have to wait until they have experienced a full-blown relapse before re-engaging. The ability to seek help at times of vulnerability or crisis could be crucial in averting relapse.

The agency should be able to work with lapse or potential lapse quickly and when the client needs it. If a client has been drug free for a number of years and had a lapse they may still be in employment or education, their relationship will probably be intact and their financial situation should not have deteriorated to the point of needing major input. A quick response can mean the difference between a lapse and the agency having to begin work again with a full-blown relapse.

10. Appendices

The following forms and handouts are currently all in draft form and will be evaluated over the course of the next 18 months. This is not meant to be a definitive or exclusive set of treatment tools and are included to give projects and workers an initial foundation on which to build their services.

The forms and handouts included in this training pack are:

1. Cocaine referral form
2. Cocaine assessment form
3. Cocaine assessment form - Checklist A: Physical health
4. Cocaine assessment form - Checklist B: Mental health
5. Care plan form (client handout)
6. Crack / heroin / methadone monitoring form
7. BBV risk assessment (cocaine)
8. Patterns of crack and heroin use (client handout
9. Triggers chart (client handout)
10. Trigger areas
11. Specific crack and heroin triggers
12. Dangerous situations (client handout)
13. Crack cravings (client handout)
14. Euphoric recall (client handout)
15. Lapses (client handout)

Cocaine referral form

Date_____

Worker's name: _____

Agency name: _____

Forename:	**Surname:**	**DOB:** **Age:**

Address: Post Code:	Tel: OK to phone this number Y/N

Disability: Y/N (if yes, please indicate)

How does client describe their ethnic origin: (please indicate)

White British	White Irish	White other	White/black Caribbean
White & black African	White & Asian	Other mixed	
Indian	Pakistani	Bangladeshi	Other Asian
Black Caribbean	Black African	Black other	
Chinese	Other		

Referral from:	Tel: Fax:

Cocaine use:

Type: Cocaine powder Crack Freebase Cocaine paste 'Speedballing'

Route: Smoke / chase Nasal IV Oral Other

Other drug use:

Heroin Cannabis Ecstasy Benzodiazepine Amphetamine Alcohol Methadone Other(s)

Physical health (client experiencing problems with):

Heart Lungs Kidneys Liver Convulsions Stomach Venal Nasal Fatigue Other(s)

Mental health (client experiencing problems with):

Anxiety Panic Paranoia Moods Depression Suicidal thoughts Hallucinations Concentration

Accommodation:

Housing association Council Hostel B&B Owned Partner Friend NFA Other

Legal situation:

None DTTO Licence Community sentence Bailed Remand Custodial

If custodial, prison and prison number:

Children: Yes / No	Childcare needed for assessment: Yes / No

Assessment times:

Which times of day best suit the client for assessment?

Early morning Late morning Lunchtime Early afternoon Late afternoon Early evening

Assessment arranged for:

Workers comments / further action:

Cocaine assessment form

Date_____

Assessor's name: _____

Agency name: _____

Personal information:

Forename(s):

Surname:

Date of birth: ___ | ___ | ___ Age: Sex: M / F

Current address:

Post Code:

Last permanent address if NFA:

Post Code:

Contact Telephone Numbers: Safe to contact on?

1. Y / N

2. Y / N

3. Y / N

GP Name:

Surgery address:

Post Code:

Telephone number:

Ethnic origin: Please state which group _____ or

How client wishes to describe themselves:

White British White Irish White other White/black Caribbean
White & black African White & Asian Other mixed
Indian Pakistani Bangladeshi Other Asian
Black Caribbean Black African Black other
Chinese Other

Referral pathway:

Please indicate how client has been referred to this agency __.

A Care co-ordinator	**F** Voluntary drug agency
B Probation service	**G** Self referral
C Social services	**H** General practitioner
D Primary care trust	**I** Other (please specify):
E Community drug team	

Drug use:

Key: **A** - Smoke / Chase **B** - Nasal **C** - IV **D** - Oral **E** - Other

Frequency: Please record if they use daily, weekly or monthly and also the number of 'hits' they would have on average per using session.

Type	Ever used	Used in last 30 days	Amount & frequency	Route	Ever shared Equipment	Age of first use
Cocaine Hydro-chloride						
Crack cocaine						
Freebase cocaine						
Speedballing co-caine & heroin						
Amphetamine						
Heroin						
Cannabis						
Ecstasy						
Illicit benzodi-azepine						
Illicit methadone						
Alcohol						

Prescribed Drugs						
Other Drugs 1						
Other Drugs 2						
Other Drugs 3						

Harm reduction:

Has client ever received any harm reduction advice around the use of crack or cocaine?

Yes __ No __

For what route have they received harm reduction information?

Smoke / Chase __ Nasal __ IV __ Oral __ Other __

Debt:

Please indicate if client has any issue relating to debt and approximate amount owed:

Gas, electricity etc: £	Council Tax: £	Rent arrears: £
Bank loans etc: £	Friends / family: £	Dealer(s): £
Other:		

Support networks:

Please indicate what forms of support are currently available or may be available to client?

Support type	Currently available	Possibly available	Not available
Partner			
Family			
Non using friends			
Support worker			
Childcare support			
Employment			
Counsellor			
Educational support			
Drug support group (NA, CA, other)			
Religion (church, mosque etc)			

Other: 1. 2. 3.			
Please ensure that client is given information on / appointments for support networks that can be arranged or introduced by the agency.			

Accommodation:

Please indicate the type of accommodation the client is currently living in:

Owned property:	Partners accommodation:
Council / Housing association:	Friends accommodation:
Hostel:	NFA:
Bed and Breakfast:	Other:

How long has the client lived in current accommodation / been NFA?

Weeks Months Years

Is accommodation in a known using area? Yes / No

Are there any rent arrears, eviction notices? Yes / No

Describe:

Is there other drug user's living in the same accommodation? Yes / No

Describe relationship (partner, friends, acquaintances etc):

Legal situation:

Please indicate the current legal status of the client, charges / current convictions and complete relevant section:

None (move to next section)	Remand in custody (b):
Licence (a):	Drug Treatment and Testing Order (a):
Bailed (c):	Outstanding warrants(e):
Serving prison sentence (b):	Community sentence (a):

Charge(s) / Current conviction(s):

1.

2.

3.

4.

5.

6.

7.

a. If currently on DTTO, licence or community sentence:

Supervising officer:

Probation office:

Post Code:

Telephone number: Fax:

Date supervision order started: ___ | ___ | ___

Date supervision order finishes: ___ | ___ | ___

b. If currently in prison:

Prison Number:

CARAT Worker:

Prison:

Post Code:

Telephone Number: Fax:

Type of sentence:

Remand Custodial (1 - 3 years) Custodial (3 - 7years) Custodial (life)

Expected court date: _____

Expected release date: _____

c. If currently bailed:

Contact with Arrest Referral Worker? Yes / No

If yes can contact be made with worker? Yes / No

Workers name: Telephone number:

d. Is client aware of any outstanding warrants? Yes / No / unsure

Charge(s):	Estimated date(s):
1.	
2.	
3.	
4.	
5.	

Solicitor's name:

Address:

Telephone:

How supporting drug use:

Please indicate how client is supporting their drug use (this may include a combination of methods):

Wages/salary:	Income support:	Street robbery:
Savings:	Dealing illicit drugs:	Using partner:
Loans:	Shoplifting:	Theft:
Commercial sex industry:	Fraud:	Burglary:

Other (please indicate):

Childcare:

Does client have any children? Yes / No (go to next section)

No. Children	Age	Living with client	Living elsewhere	No. dependent on client
1.				
2.				
3.				
4.				
5.				

Are there any legal issues involving the children? Yes / No

If 'Yes' please detail:

Is there any involvement with social services? Yes / No

If 'Yes' please provide contact details:

Designated worker:

Address

Telephone:

Please indicate what kind of support would client like regarding dependants?

Support with parenting skills:	Support with legal issues:	Support in working with Social Services:
Childcare during treatment:	Support in approaching social services:	Family counselling:

Other forms of support:

Future action:

Please indicate the actions that will be undertaken after this assessment:

Give harm reduction information	Referral for community assessment	Referral to other more suitable drug agency	Arrange further appointment
Referral to appropriate physical health care	Referral to appropriate mental health care	Referral for accommodation support	Support with debt issues
Information on support networks (NA, CA etc)	Arrange appointment with family / friends	Liaise with criminal justice worker / solicitor	Develop initial relapse prevention strategies
Refer / support with childcare issues	Give information on service / drug use	Referral to counselling agency	No further action

Agreed by:

Client: Assessor:

Signature: Signature:

Assessor's notes:

Cocaine assessment form - Checklist A: Physical health

Please indicate if client has experienced any of the following **ever** and in the last **30 days**.

NB If in any doubt at all about any physical health problem(s) please refer to appropriate healthcare agency.

When more than one symptom present, possible indicators of:

A - TB **B** - 'Crack Lung' **C** - Stroke **D** - Cardiovascular problems

Symptom:	Ever experienced	In last 30 days
Weight loss (A)		
Night sweats (A)		
Insomnia (A)		
Loss of appetite (A)		
Persistent cough (A)		

Coughing up blood (A)		
Coughing up dark bile (B)		
Breathing difficulties (B)		
Speech difficulties (C)		
Loss of movement (face, limbs etc) (C)		
Chest pains (D)		
Numbness / tingling (arms and hands) (D)		
Pains in shoulder (D)		
Kidney pains (D)		
Convulsions / fitting		
Blackouts		
Tiredness / fatigue		
Nausea		
Stomach pains		
Muscle pains		
Tremors / shakes		
Vein damage / abscesses		
Nasal damage / bleeding		
Other problem (s):		

Physical health cont.

Health problems that have been diagnosed / or have had treatment for in the past:

1.

2.

3.

4.

If sickle cell or epilepsy diagnosed is client experiencing an increased amount of attacks?

Yes / No

Any current medication (please list):

1.

2.

3.

Is medication being regularly taken? Yes / No

Other issues:

Cocaine assessment form - Checklist B: Mental health

Mental health

Please indicate if client has experienced any of the following **ever** and in the last **30 days**.

NB If in any doubt at all about any mental health problem(s) please refer to appropriate healthcare agency.

Symptom:	Ever experienced	In last 30 days
Anxiety		
Panic attacks		
Paranoia		
Mood swings		
Depression		
Suicidal thoughts		
Visual hallucinations		
Auditory hallucinations		
Lethargy		
Difficulty in concentrating		
Memory problems		
Other		

Mental health cont.

Mental health problems that have been diagnosed / or have had treatment for in the past:

Any current medication:

Is medication being regularly taken? Yes / No

Cocaine assessment form - Checklist C: Client self perception

Self perceptions: Please indicate how the client feels about themselves:		
Depressed:	Disillusioned:	Angry:
Anxious:	Positive about self:	Low self esteem:
Other:		
Please indicate how the client feels about receiving treatment for their drug use:		
Doesn't think treatment will work:	Coerced into treatment:	Worried about entering into treatment:
Looking forward to treatment:	Its an opportunity:	Not sure:
Other:		
Please indicate how the client feels about their drug use:		
Dissatisfied with lifestyle:	Doesn't want to take drugs again:	Would like to control drug use:
Only wants to address problematic drug use:	Doesn't feel drug use is a problem:	Not sure:
Other:		

Care plan form

Client's name: _____DOB_____

Agency name: _____

Action completed from assessment form :

Please indicate the action agreed after initial assessment and date achieved:

Action agreed	Date	Sign
Harm reduction information given:		
Referral to appropriate physical health care:		
Referral for detoxification		
Referral for prescription/s		
Information on support networks given:		
Referral / support given with childcare issues:		
Referral for community assessment:		
Referral to appropriate mental health care:		
Appointment arranged with family or friends:		
Information given on service / cocaine use:		
Referral for accommodation support:		
Liaised with criminal justice worker / solicitor:		
Referral for counselling:		
Support given regarding debt issues:		
Developed initial relapse prevention strategies:		
Other (specify):		

BBV Risk assessment completed:

Yes / No

Has BBV test been requested?

Yes / No

Has client been informed of Pre / Post test counselling?

Yes / No

Information consent:

I give the _____ consent to contact and share information with the following people / agencies:

Agency / Person:	Date:	Sign:

Care plan:

Care plans should be agreed upon and involve the client in the process:

Main identified needs:

1.

2.

3.

Date:	Agreed Action:	Sign:

Care Plan Review: **Date:** Care plan reviews may be done in conjunction with other significant agencies that are working with the client. Other agencies involved in care plan review: 1. 2. 3.
Main needs identified: 1. 2. 3. 4. 5. 6.
Are the main needs identified still relevant to client? Yes / No
If 'no' what areas are not being addressed? 1. 2. 3.
What is clients perception of progress:
Any other issues / comments:
Signed:

Crack / heroin / methadone monitoring form

This form can be used to identify the different patterns of crack and heroin use and helps to monitor the changes in crack, heroin and methadone consumption during treatment.

Client Name: **D.O.B**

	Cocaine	Heroin	Methadone
Pattern of use:	Binge Daily	Daily	Daily
Route of use:	Smoke Nasal IV oral	Smoke / chase Nasal IV	Oral IV
Amounts used:	£	£	Mls
Increase / decrease?			
Date information recorded:			

Client Name: **D.O.B**

	Cocaine	Heroin	Methadone
Pattern of use:	Binge Daily	Daily	Daily
Route of use:	Smoke Nasal IV oral	Smoke / chase Nasal IV	Oral IV
Amounts used:	£	£	Mls
Increase / decrease?			
Date information recorded:			

Client Name: **D.O.B**

	Cocaine	Heroin	Methadone
Pattern of use:	Binge Daily	Daily	Daily
Route of use:	Smoke Nasal IV oral	Smoke / chase Nasal IV	Oral IV
Amounts used:	£	£	Mls

Increase / decrease?			
Date information recorded:			

Blood borne virus (BBV) risk assessment

Assessment date: _____ Worker _____

Personal information:

Forename(s):

Surname:

Date of birth: ___ | ___ | ___ Age: Sex: M / F

Sexual health:

Please indicate whether client has practised safer sex (explain)?

Always Most of the time Sometimes Never

How many sexual partners has client had over last 10 years?

None 1-5 5-10 10-20 20-30 More

Equipment sharing:

Age at first equipment sharing ___ Never shared equipment ___

Route of use	Shared equipment in last 30 days?	Ever shared equipment?	Ever passed on using equipment?
Intravenous			
Smoking (pipe)			
Snorting			

History of previous testing for Hep B/C and HIV:

Date of first test __ | __ | __ Date of last test __ | __ | __

BBV	Never tested	Tested once	More than once	Dates	Results P / N
Hep B				1. 2. 3.	
Hep C				1. 2. 3.	
HIV				1. 2. 3.	

Clients understanding about contracting or transmitting BBVs:

Clients concerns about contracting or passing on BBVs:

If client has not had any tests would they like to be tested:

Yes / No

Patterns of crack and heroin use

1. How do you physically feel before you use crack?

Shaking	_	Heart beating	_
Energised	_	Fast breathing	_
Sweating	_	Stomach churning	_

Other:

1a. How do you physically feel before you use heroin?

Shaking	_	'Wired'	_
Cramps	_	Fast breathing	_
Sweating	_	Physically sick	_

Other:

1. How do you feel emotionally before using crack?

Anxious	_	Depressed	_
Excited	_	Bored	_
Guilty	_	Angry	_

Other:

2a. How do you feel emotionally before using heroin?

Anxious	_	Depressed	_
Excited	_	Bored	_
Guilty	_	Angry	_

Other:

1. Is there a specific time of day, week, and month when you use crack?

Afternoon	_	Evening	_
Friday's	_	Weekends	_
Monthly	_	Anytime	_

Other:

1. What places do you use drugs in?

Home	_	Partners/friends house	_
Street	_	Crack house	_
Club	_	Pubs/bars	_

Other:

1. What areas do you use drugs in?

Home area	_	Work area	_
Social area	_	Dealing area	_
Where user friends live	_	Area changes	_

Other:

1. Who do you use drugs with?

Alone	_	Partner	_
Friends	_	Other users	_
Smoking partner	_	Dealer	_

Other:

1. How do you get the money to use?

Giro	_	Work	_
Dealing	_	Crime	_
Savings	_	Selling/borrowing	_

Other:

1. How much money gets you thinking about using?

£5 -£10	_	£15 - £20	_
£40 - £50	_	£90 - £100	_
£150 - £200	_	£200 - £300	_

Other:

1. What equipment do you use?

Cigarette papers	_	Pipes	_
Spoons	_	Foil	_
Burner/lighter	_	Syringes etc	_

Other:

Now look at the answers and use the next page to help you try to develop some basic Relapse Management strategies.

Awareness Action Plan

Name:

1. How do you physically feel before using crack / heroin?

Become aware of how you feel physically and use this as an indicator. Most of the physical feelings before crack use are down to the release of adrenaline and can be controlled. Try acupuncture, breathing exercises, relaxing oils, herbal teas, massage etc to help you cope. Prescription or detoxification can help work with your heroin use.

Personal plan:

1. How do you emotionally feel before using crack / heroin?

Again use these as indicators, but also be aware of situations that may develop these feelings. E.g. if you know a situation or person usually makes you feel angry or depressed look at ways of coping with this or avoiding the situation. Also look at the part that you have to play, are you sparking off the situation to be able to use it as a justification?

Personal plan:

1. Is there a specific time of the day, week, and month when you use crack?

This will very much depend upon your pattern of crack and heroin use, but once you are aware of your danger times you can develop strategies that make these times less of a problem. E.g. if your using usually begins at a certain time then look for alternatives, try to be in a safe place with people that will support you.

Personal plan:

1. What places do you use drugs in?

Most places that you use in can be avoided if you really want to. Places have strong associations and will almost always contain the people that you use with. Avoid them no matter the reason. If you use at home try to change the environment, move furniture around, get rid of particularly strong associations like tables etc.

Personal plan:

1. What areas do you use drugs in?

Some of the areas that are associated with using for you can be difficult to avoid so you need to develop strong strategies. Streets can be avoided and you can change your route it may be less convenient but will help to keep you safe. Other areas can be avoided altogether and there should be no reason to enter them other than to use. Be aware!

Personal plan:

1. Who do you use with?

Avoid people that you use with. Most of these will be drug using acquaintances with the relationship based around using rather than friends. If they are friends then they will understand why you cannot have contact with them. If you use alone then try to be with people at your danger times. Members of the family and partners can be difficult and you have to look at what you want most?

Personal plan:

1. How do you get the money to use?

Receiving money or knowing when you are going to get it, can be one of the biggest triggers to use. These times can be extremely dangerous and you need to work out ways of coping with this. E.g. always cash your giro when your with someone you trust, change the post office if the dealers hang around the usual one. Get rid of cash point cards, arrange for someone else to control finances etc. Crime also triggers adrenaline so will make your cravings more acute, avoid.

Personal plan:

1. How much money gets you thinking about using? As stated before money is one of the biggest triggers to use, and having the money with you or available to use can be a major temptation. You need to be aware of the amounts that spark you off. Whatever that amount try not to carry the money around with you especially at danger times. Also be aware that when you stop using your pattern may change and the amount becomes less.
Personal plan:
1. What equipment do you use? If you are serious about giving up you need to get rid of everything that you associate with using. Throw these things away and check your house for any things that may be lying around including foil, rubber bands, pens etc. Be aware that you don't buy anymore without thinking. If you use on an inhaler then ask your Doctor to change it to one that works on a propeller system.
Personal plan:

Triggers Chart

Everybody is an **individual** and so is your habit. In order for you to increase your chances of getting off crack and heroin you need to understand what your main triggers are. Once this is understood you can then start to develop strategies that will help you avoid / cope with these triggers.

Take a little time and think about the events leading up to your use. Trace the steps back and try and identify the first things / events that set you upon a course to use. List these in the first column. Once this is done look at each individual trigger think of ways that these can be avoided or coped with. Talking to other people about these triggers can sometimes help to develop new ideas.

Trigger	Action

1. 2. 3. 4. 5. 6. 7.	

If you think that an action to avoid triggers may be difficult to do then seek support for this or discuss with somebody else to come up with an alternative. Once you are happy with your actions **stick to them.** Don't be tempted to put yourself in danger for a test!

Trigger areas

Areas can have very strong connections to using and can be associated with particular places, other users and most importantly dealers. It is vitally important to be able to avoid these. Even if you live in a dealing you can avoid 'hot spots' by taking alternative routes, catching a different bus and changing what shops / post offices you use.

Identify the areas that are most dangerous for you, why are they dangerous, think of all the possible reasons that you may have to go there and then work out the action needed to make it safer.

For example:

Danger area?	Possible dangers?	Why go in area?	Actions
1. Local shops	Dealers and users present.	Cigarettes / Post Office.	Change Post Office / where I get cigarettes.
2. Main Street	Crack House on street	Good friend lives on same street.	Get him/her to meet me elsewhere.

Danger area?	Possible dangers?	Why go in area?	Actions
1.			
2.			
3.			
4.			
5.			

Make it a rule that you avoid these areas and if you find that you have entered them be aware that you might be setting yourself up and will have a higher likelihood of coming across trigger situations and developing a craving.

Specific crack and heroin triggers

It is important to understand that crack and heroin can trigger each other off and lead to using. This can happen in a number of ways so it is vital that you are aware of the possible dangers. Use the form below to help work out how these situations can happen.

Scenario	Thinking / justifications	Dangers / what could happen?
• You've been off crack and heroin for some weeks now and have successfully completed a detox • You have a strong craving for crack and act upon this by scoring a few rocks	• I'll just give myself a bit of a treat • Crack isn't physically addictive so I can just have the one pipe • My problem was when I was taking both together not one at a time so I should be OK • etc	• After using crack you will always get to the 'comedown' where you will be in a 'wired' state. Heroin is what you used to help you cope with this state. • Scoring crack will probably put you in touch with your old dealers who most likely sold you heroin as well…
• You've been off crack and heroin for some weeks now and have been stabilised on a methadone script • The methadone does not give you any of the 'highs' that you experienced when you were taking crack or heroin	• Life seems a little boring and you start thinking about giving yourself a little treat every now and again • My problem was with crack and heroin not crack and methadone • etc	• Dealing with the 'comedown' and feelings of being 'wired' will need you to needing a 'comedown' drug. Which one would it be… • Scoring crack will probably put you in touch with your old dealers who will most likely sell you heroin as well…
• You've been off crack and heroin for some weeks now and have been stabilised on a methadone script • You don't feel that the script is big enough and that you need to use heroin on top	• The Doctor didn't give me enough methadone so I have no choice but to use on top • Methadone doesn't give me the same feelings as heroin • etc	• The heroin dealer in a lot of cases will also sell crack and will try to sell both to you. • If they dealer doesn't sell crack then you may be in an area that does and can you resist…
Work out your own scenarios from past experience or what you might know about yourself…		

Remember they can spark each other off just by association! Punch is not the same without Judy!

Dangerous situations

Developing awareness of dangerous situations that may lead to using can be difficult when you have only just stopped the use of crack and heroin. This is because situations that are now dangerous where once thought of as opportunities. It is vitally important that you start to anticipate these situations as much as possible and develop plans to cope with them if they do arise. In anticipating these situations you need to have an awareness of situations, emotions, people and places that may have lead to a using event (refer to you triggers chart or complete one if you haven't already done so).

Use the table below to help develop plans for dangerous situations:

Suggested plans	**Personal plans**
1. Anticipate dangerous situations	Situations that lead me to crave: 1. 2.
2. Leave or change the situation	Safe places I can go: 1. 2.
3. Distract yourself with things you like to do	Good distracters: 1. 2.
4. Have a list of emergency numbers	People I can call in an emergency: 1. 2.
5. Remind yourself of you success to date	My main successes to date are: 1. 2.
6. Change the thoughts of using to positive thoughts	Positive thoughts: 1. 2.
7. I will put off the decision to use for 15 minutes. Remember that smoking crack may lead to heroin being used to handle the come down.	Techniques I can use to relax me during those 15 minutes: 1. 2.

Source: Adapted from All Purpose Coping Plan, Kathleen M. Carroll Ph.D, 1998

Remember that dangerous situations may be normal parts of everyday life such as going to the corner shop, receiving money or being upset. It is impossible to anticipate everything so make sure you know your personal emergency plan and stick to it!

Crack cravings

Cravings will be one of the biggest areas that you will have to deal with when coming off crack. There are four main areas of craving associated with crack use and you need to be able to understand where they come from, how they work, how they were triggered and more importantly how to avoid / stop them.

There are two main things to remember:

- They always need a trigger (face, place, £ etc)
- They are not a need like heroin, they are a <u>want</u>

What is a craving?

Cravings with crack are a combination of physical, chemical & emotional factors:

- Physical feelings of sweating, heart beating faster, butterflies in stomach, anxiety and increased breathing rate come from the release of adrenaline into the system triggering off the **flight** or **fight** response.
- Compulsion to use, single minded behaviour (the mission) and a belief that you need the drug come from the imbalance caused to the brain chemicals. Also you may not be thinking clearly due to lack of sleep.
- Emotional factors like depression, celebration, boredom and isolation can provide justifications to use and contribute to irrational thinking.

Types of craving?

1. **Craving when using:** These are usually triggered by the initial 'crash' or 'come down' which can be experienced after each hit. The down experienced, when you have felt so high, makes you want to use more even when you know that the 'buzz' felt is not going to be as high as the last one.

2. **Open Craving:** As the name suggests you are fully aware of what is happening and what you want. This type of craving may fit into your pattern of use such as time of day, day of the week, faces and places. The important thing to remember is that you know about it and can choose whether you act on it.

3. **Hidden Craving:** This type of craving is a little more complicated and often appears when you are trying to give up. A string of events may build up to lead you into a using position so that you are not fully aware of it until it too late. In effect you end up kidding yourself into a using situation.

4. **False Craving:** This usually happens further down the line of recovery. You have been drug free for some time and are feeling confident about life. An event happens that you may feel anxious about (first day at college, work etc) or that generates real fear (threats, dental treatment etc). These events will trigger off the fight or flight response. This can feel like a craving and start you thinking about using.

How to cope with cravings?

If you are feeling the need to use just remember:

S . C . A . R . E .

S**upport:** Dealing with a craving on your own can sometimes be very hard. Is there anybody that can offer you support and make it less likely that you will use. Support networks like Narcotics Anonymous, drug free friends and family can all be useful. Whatever your support networks are, make sure you use them. Be aware of picking the wrong support (hidden craving). Make sure you are not going to get support from someone who is likely to feed your craving so that you end up using together!

C**onsequences:** Most of the time when you crave you are just thinking about the 'buzz'. Its like playing a video reaching the good bit of a film and then pressing pause. Take time to play the tape forward. How will you feel with the come down? Will you be likely to commit crime to support your binge? How will the loss of money effect you? What risks to your health? How will you feel about yourself? You have probably been through all of the above and will therefore be able to predict the possible consequences of use. Do you want these to happen?

*A**wareness:** Once you understand where they come from it is easier to deal with them. Understanding your individual triggers is essential for this process. Think of them as a ladder with each rung taking you a step closer to using. The earlier you spot what is going on, the easier it is to jump off. If you wait before its one step off using then most of the time it's too high to jump!*

R**elaxation:** Nature has given you a cut off switch for coping with the release of adrenaline. This is very simple and effective. Just remember:

Deep breathing kills the feeling

This is how most complementary therapies work and also why you found using a 'downer' drug worked when you were feeling 'prang' or 'wired'.

E**ducation:** If you get close to using or have a lapse, remember to learn from the experience. Your crack and cocaine use will be littered with times when you have repeated the same mistake again and again. Learn from these so that you can strengthen your prevention strategies and stop them from happening again.

Word of warning

Be careful not to set yourself up. Putting yourself in dangerous situations to test how far you have come is not a good idea. This sets up a situation whereby you can ignore danger. ' It's OK because I was OK the last time' doesn't mean that its going to be OK **now**. Never take anything for granted and remember that emotional factors like depression, boredom and celebration can effect the way that you are going to react to a situation.

How I feel when I crave	How I can stop the cravings
1. 2. 3. 4. 5. 6. 7.	

Be aware how heroin use can lead to crack cravings and visa versa

Euphoric recall

Euphoric recall is basically looking at something with rose tinted glasses on or just remembering the good bits.

Imagine that you are watching a trailer of a movie, the general plot is given but only the highlights (good bits) are shown. Highlights of a movie can make it seem really good and make you want to watch it. The reality is often that these were the best bits of the film and the rest is not up to expectations and you wonder why you bothered going to see it.

Euphoric recall with crack and heroin can act in the same way in that only good memories are shown which help to build up your expectations and anticipation of drug use. The reality however of living the film **'Some of My Best Using Experiences'** is that you're left feeling unsatisfied, depressed, anxious and craving etc. As well as these feelings you may also be in debt, facing consequences of your actions and in trouble with partners, family and friends.

You need to build up an awareness of how euphoric recall works with you and also how other people can help to spark this off. Think off how many times you have been talking with other users about experiences and how that has triggered off a craving. Once you are aware of how these discussions about the 'good times' effects you try and avoid them.

The good and bad of using

Look at the reality of using so that the reality of you using is understood. List both the good and bad elements of crack and cocaine use. Be truthful and honest don't fool yourself!

Good	Bad

This is your reality of using, no trailers and no highlights, remember this next time you want to see the film. Ask yourself: **Is it worth it? Is this what I really want to do?**

Listed below are a number of methods that you can use to deal with euphoric recall:

Forced Memory Connection:

This involves you remembering the reality of crack and heroin use for you. In effect it's remembering that you have seen the film lots of times before and it doesn't get any better. Use the good and bad list to help you remember the realities of your use and what has brought you to this point of wanting to stop using.

Thought Stopping:

When you have become aware that you are thinking about the so called 'good times', stop the thought. Recognise where you are heading and stop it there, look at what has sparked off these thoughts and deal with the situation. This will usually be a trigger.

Thought Replacement:

Once you are aware of what you are doing you can replace these thoughts with ones that are more positive for you. Think about the things that you want to achieve and positive things in your life, no matter how small they may seem. Don't get into depressive thoughts as this can lead you back into thinking about using crack or heroin to make you feel better.

Points to remember:

Euphoric recall will often lead to craving for crack, which can in turn lead to heroin use. Remember that this is just an exaggeration of your 'fight and flight' response. You don't really need crack you just think that you do.

Use some of the following techniques to help reduce the levels of adrenaline in your system:

- Slow breathing
- Burn relaxing oils
- Have auricular acupuncture
- Use relaxing herbal teas
- Talk to somebody you trust and that will offer positive support
- Get yourself into a safer environment

Also be aware that you don't start to set yourself up and provide yourself with justifications to as to why you should use such as:

X I'll only have one 'rock'/line

X Its boring being straight

Using dreams

On occasions you may find yourself dreaming about the lead up to using and when you awake it feels like you really are just about to use. This is a similar process to having a nightmare. When you feel threatened and scared in the nightmare you release adrenaline and wake up with your heart beating, fast breathing and the sweats. The same is happening in a using dream, adrenaline is being released because of the anticipation of using and when you awake the physical feelings of use feel very real.

The points above can be used to help reduce the adrenaline levels after a dream.

Learning from lapses

A lapse does not mean that you have gone back to square one. If you feel totally negative about the incident then you will miss the opportunity to learn from your mistakes and maybe make the same mistake again.

What you need to do is understand:

- **What happened?**
- **How it happened?**
- **How can you stop it happening again?**

Start by tracing the events that led to you using. You may need to go over things a few times going one step further back to trace the initial set up. Look at whom you were with? How did you feel emotionally / physically? Where did you get the money? What justifications were used?

Using event
What happened before that?
And before that?
And before that?
And before that?
And before that?

Now that you have a better understanding of what happened and how it happened, how can you stop it happening again?

1. 2. 3.

References:

Models of Care: For the Treatment of Drug Users, *NTA*, 2002

Crack Resource Pack, *NTA/COCA*, 2002

Quads: Professional Competencies for Alcohol and Drug Workers, *Drugscope*, 2000

Commissioning cocaine / crack treatment, *NTA*, 2002

Process and Intervention Chart, *James, Robin & Gray, COCA* 1999

A cognitive Behavioural Approach: Treating Cocaine addiction, *Kathleen M. Carroll,* NIDA, 2001

Report of an independent review of drug treatment services, *Task Force to Review Services for Drug Misusers, Department of Health,* 1996

Auricular as an adjunctive treatment for cocaine addiction, *C. Otto et al, American Journal on Addictions,* 7(2), pp. 164 - 170, 1998

Expert Stimulant Group Findings, *NTA, Unpublished* 2002

National Crack Cocaine Treatment and Response Strategy, *G. Haynes, T. Bottomley, A. Gray, Unpublished,* 2000

National Cocaine Treatment Study: Report To The Task Force, *M. Donmall, N. Seivewright, J. Douglas, T. Draycott and T. Millar, Manchester University* 1995

Street Business: The Links Between Sex And Drug Markets *T. May, M. Edmonds, M. Hough and C. Harvey, Home Office* 1999

Drug Testing Arrestees, *Home Office Research and Statistics Directorate, Home Office* 1998

Drug and Alcohol National Occupational Standards (DANOS), *Healthwork UK,* 2002

A.R. Crossman, D. Neary **Neuroanatomy** (2000) Churchill Livingstone.

Other information has been compiled from COCA Members working experiences, website's to numerous to mention, NADA, T.B. Foundation, NIDA, Radio 4, various Newspaper articles, National Institute of Health (USA), Heart Information Network, Schaffer Library of Drug Policy and of course users experiences.

The information in this pack is taken from a variety of different sources and written from a drug workers point of view. It is not meant to be a definitive document and the authors would advise that information be constantly checked as it can become out of date very quickly.

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