More Than Clean Works?

An Investigation of the Role of a Needle Exchange in Drug Using Behaviour

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Peace.

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Abstract for Section B: Research

This study explores the role of a needle exchange service in the drug using behaviour of its clientele with a specific emphasis on sharing injecting equipment. Theoretical perspectives that have attempted to understand the role of needle exchange in changing drug using behaviour are critically reviewed and placed in the context of wider debates about approaches to changing drug using and health behaviour. Different perspectives can be broadly differentiated by the extent to which they focus on the individual and their beliefs or the social context including social interactions in which the behaviour occurs. A definition of motivation is proposed as a potentially integrative concept in which a number of influences on behaviour can be considered and understood in terms of competing contingencies that moderate the potential for sharing injecting equipment over time both between and for individuals. A theoretical framework outlined by Derek Layer is also used to consider the literature reviewed in terms of different levels of explanation. This enables the interrelations between different perspectives to be explored.

This study is based on empirical research involving semi-structured interviews with six clients and three staff of a needle exchange. It employs a grounded theory approach which identifies the importance of social support provided by the service in relation to self image and drug using behaviour. Further findings provide useful information about the nature of the local drug using network as well as the function and quality of client / worker relationships in the service. These findings are considered using Layder's theoretical framework to explore interconnections and to reflect on aspects of clinical practice and implications for needle exchange service delivery.

Section A

Preface

Introduction to the portfolio

Preface

Introduction to the portfolio

This preface describes the development of my interests in researching substance use and related health behaviours and introduces the three sections of the thesis. It also outlines a rationale for the methodological approach used in Section B.

The work in this portfolio reflects aspects of and interests associated with my practice as a clinical psychologist in the addictions field. Since qualifying in 1993, I have worked with substance-using clients in various settings including alcohol and drug services, a sexual health clinic and a needle exchange. In my approach to this work, the fact that people use drugs and alcohol does not surprise me: altering states of consciousness has a long history in human experience (Plant, 1999). However, I have found it interesting to consider why most people can use substances with relative impunity, whereas a small proportion of others (over-represented among my clients) develop significant associated problems and persist in substance-using despite these profound difficulties. This has led me to reflect on whether problematic substance use and related health behaviours can be understood solely by looking within the individual.

As a clinical psychologist, I believe my role is to facilitate processes of change amongst the clients I see, ultimately to enable them to make changes in their behaviour. Yet what I have learnt from my substance-using clients is just how complex are their attachments to using substances and the processes involved in changing these behaviours. Of course it is this complexity which is so fascinating, as is the fact that psychologists are not the only people charged with reducing substance use; a bewildering array of moral, political, social and medical discourses emerge in the context of trying to understand, control and change this behaviour.

My experience of working in this area has led me to think broadly about processes involved in behaviour change and to take a pragmatic stance to the "treatment" of substance use. A number of ideas that emerge through this portfolio are those that enable me to maintain my interest,

persistence and belief that the work I do has some meaning.

My interest in these ideas developed through my undergraduate studies and MSc in clinical psychology. My thesis for this masters degree investigated compliance with a Hepatitis B vaccination schedule among a group of injecting drug users. Completing this study was an important learning experience for me. It can be seen as an expression of interest in substance use and health-related behaviour which is also manifest in the research submitted as part of this thesis. The study also attempted to reduce psychological constructs to measurable entities for the purpose of statistical analysis. While this may sometimes be a useful exercise, my feelings when writing up the study were that I was missing the full picture. The participants were concerned about their health and motivated to comply with the treatment, but the issues that impacted on whether they returned for doses of the vaccine could *not* be understood only at a psychological level. After qualifying, I realised that my frustration in relation to this project was that, as an applied clinician, I was working with people who cannot be detached from their social context. And that, in David Smail's words (1990),

> "people's 'inner worlds'.... are the products of and directly traceable to the influences of material structures of the 'outer world'". (pg. 3).

The significance of this when working in the NHS is obvious. The clients I see are usually materially disadvantaged and understanding the impact of this on their abilities to make changes in their lives is an important part of my clinical practice. Consequently, as a clinician, I am continually seeking to understand with my clients the reasons for their behaviour and how they may change it within a broad psychosocial context.

During my training, a concept often invoked in relation to the practice of clinical psychology was that of the "scientist-practitioner". My understanding of this notion was applying and developing academic knowledge through clinical work and research. After qualifying I initially believed I was failing in this role. For the reasons noted above there appeared to be a gap between much of academic psychology and my clinical work. Over time, however, I have come to realise that part of this sense of failure was my narrow understanding of "science". That is based on positivist epistemological and ontological assumptions about the world and the ways we can understand it.

This is also a reflection of a wider debate within academic psychology (Parker, 1989).

Part of my motivation to undertake this thesis was to engage with these ideas and attempt to define some value and meaning of my work outside my immediate working environment. In this sense, I see it as an important part of my continuing professional development. I wanted to use a research methodology that would be relevant to my work and capture the essence of what, as a clinician, I do on a day to day basis. Orford (1995) articulates these issues in relation to qualitative research. He writes that qualitative research methods may be particularly attractive to applied psychologists for three reasons. First, they enable a focus on what he calls "the insider's view". As stated above, in my clinical work I am constantly party to people's accounts of their experiences and understanding of the world. Secondly, qualitative methods are used to understand the "wholeness and complexity" of events in the real world. This also describes the aims I have towards my practice as a clinical psychologist. Thirdly, qualitative methods allow for the development of inductive and substantive theory. For me this is the main purpose of this thesis: it is an opportunity to use ideas from my clinical experience to develop a theoretical understanding of issues which can in turn be used to inform clinical work. This is, I argue, the essence of reflective practice. The following sections introduce the following three sections of this thesis.

Introduction to Section B: Research

The title of this research is: *More than clean works? An investigation of the role of a needle exchange service in drug using behaviour.* It explores the part which a needle exchange project plays in the drug using behaviour of its clients.

This study was initiated for two reasons. The first was a consequence of my clinical involvement with the service for one afternoon a week, over a period of one year. This included facilitating a clinical supervision group for the staff of the service in which issues related to working practice were discussed, as well as the opportunity to work with clients directly as part of the staff team. I was able to experience and observe interactions between staff and clients as well as between the

clients themselves and to build up a picture of how the service was used. During this time I became aware that the service was being used by clients for reasons other than obtaining injecting equipment. Some appeared to be actively seeking interactions and forming relationships with the staff. This led me to consider the significance of these relationships and the function they may serve for clients.

The second reason for this study was that, during the time I was involved with the service, a campaign started within the local community aimed at closing it down. The reasons for this campaign were varied but centred around the service being a focus for drug dealing and the suspected source of used injecting equipment discarded in the local area. The nature and impact of this campaign on the service and its staff and clients would have been an interesting study in its own right. However, responding to this campaign, the health authority put forward a number of proposals which ultimately were to lead to a change in the configuration of the service. This provided the impetus to attempt to capture the quality of how the service operated, particularly how it was used by clients and how this potentially affected their drug using behaviour. It was hoped that this information could be used to give a clinical perspective to the decision making process about the future of the service. While some of the findings of the study were used in this way, the intense scrutiny and involvement of the media, local government and the Department of Health gave a political urgency to resolving the issue. As a consequence, some aspects of the service were rapidly changed, most notably a reduction in the opening hours, without a full evaluation of the potential impact of these changes on the clients themselves.

This research exists as a snapshot of how the service functioned before these changes occurred. However, it is hoped that the ideas presented in this work are relevant to thinking about the potential value and working approach of the staff in the service studied, both for future developments of this project and more generally in relation to issues of working practice in other services for drug users. Ideas are also raised in this research about injecting risk behaviour that may also have some general utility. This study can be considered as a piece of applied clinical research. In short it originated from ideas formulated during clinical work and is an attempt to explore and answer questions about the meaning of social interactions within the project and to

induce further understanding of how needle exchange, as a health intervention, may function to reduce injecting risk behaviour. A brief outline of each chapter follows.

Chapter one reviews the literature and outlines issues related to understanding injecting risk behaviour and interventions that aim to reduce it. The historical development of needle exchange, evaluations of needle exchange and theories underpinning these interventions are described. Since needle exchange is ultimately concerned with drug users' injecting behaviour, research and theories that have attempted to explain the sharing of injecting equipment are considered. Ideas and theories about this potentially risky behaviour are based on concepts from the broader area of health behaviour, including more general ideas about processes involved in behaviour change. This wealth of literature can be understood in terms of the extent to which it focuses on individual or social processes. A definition of motivation is introduced as a potentially integrative concept in relation to the theories of risk behaviour discussed. This definition is based on Smail's (1990) work which highlights the influence of social factors on behaviour. It is used as a way of drawing explanations from both the social and individual levels together. To link the literature to the research questions, a theoretical framework or research map is described based on Layder's (1993) ideas. This enables the complex and multiply determined nature of drug using behaviour and theories from different "levels of explanation" to be considered as well as the interconnections between these levels.

Chapter two outlines the methodology used in the research. I argue that, for the reasons outlined above, the nature of the research question and its focus on process necessitates a qualitative approach. The procedures and description of the research process are also outlined.

Chapters three to eight outline the findings from the research which are reported in the context of analysis and discussion. Each chapter represents an element, or part of an element, of the research map described in Chapter one. This enables an in-depth consideration of the themes that emerge in the study and considers how the service studied may impact on drug using behaviour. These chapters provide the basis to **Chapter nine**, which draws together the conclusions and reflects critically on the research process. Also included in this final chapter of the research are

some general recommendations for service delivery that emerge from the findings.

Introduction to Section C: Case study

The case study presents work I have undertaken with two crack cocaine using clients. It is an example of my day to day clinical practice. I have chosen to report this work because it highlights aspects of my role as a clinical psychologist within a multidisciplinary drug service. The services in which I have worked have been associated with the treatment of opiate users. Substitute drug prescribing is central to the treatment of these clients but has not been demonstrated to be effective with stimulant users. As more stimulant drug using clients have approached services for help, I and clinical psychologist colleagues have had the opportunity to put forward an alternative model of treatment, based on psychological principles. Consequently, my second reason for reporting this work is as a description of core components of an intervention that I have found useful in working with this client group. Two cases are presented to illustrate issues of reflexive practice.

Introduction to Section D: Critical review of literature

The critical review of research concerns psychological interventions with cocaine users. In this era of clinical governance it is appropriate to consider the effectiveness of clinical approaches. This review has been useful in reflecting on my clinical practice (see Section C). In my work with cocaine using clients I have been struck by how difficult they can be to engage in treatment and how they present with specific needs and issues related to their cocaine use. My critical approach to research in this area is based on what might be generalised from these North American research trials to the experience of working with cocaine users in a NHS outpatient drug service.

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Section B

Research

More than clean works?

An investigation of the role of a needle exchange service in drug using behaviour

Chapter 1 Needle exchange and injecting behaviour: A theoretical overview

1.1 Introduction

Needle exchange is the provision, usually cost free, of needles and syringes to injecting drug users. Although it has become an established feature of services for drug users in the UK, it is still a relatively recent addition. This chapter first describes the historical development and evaluation of needle exchanges in the UK. It reveals some of the theories underlying needle exchange as a health intervention and sets a context to consider theories of health behaviour and their value in understanding drug using risk behaviour. These theories can be broadly differentiated by the extent to which they focus on the individual or social context and interactions. A definition of motivation is proposed as a potentially integrative concept in which a variety of influences, both individual and social, can be seen as influencing injecting behaviour. A research framework is also outlined which aims to draw these different theoretical perspectives together and as a useful way to consider individual behaviour within a social context. This framework is used later in this thesis to analyse the findings from this study and the potential role of needle exchange in safer drug using behaviour.

1.2 Historical development of needle exchange

Through the 1980s there was a significant change in UK government policy towards needle exchange. In the early 1980s there were no needle exchange programmes and community pharmacists operated under a recommendation by the Royal Pharmaceutical Society to supply injecting equipment to patients only for therapeutic purposes (Derricott et al., 1999). This can be seen as a policy of restricting drug users' access to injecting equipment. However, by the end of the decade, over 200 needle exchange schemes were in operation.

A number of factors were significant in this rapid emergence of a new form of service provision. First, the identification of the Human Immunodeficiency Virus (HIV) in populations of injecting

drug users. HIV is a blood-borne virus and can be transmitted through sharing injecting equipment. By 1986 there was evidence of an HIV "epidemic" among injecting drug users in Edinburgh. In a sample of 182 users, 51% tested HIV positive (Robertson et al., 1986; Brettle et al., 1987). Secondly, this evidence of groups of drug users becoming infected with HIV raised concerns among policy makers. In 1986, responding to local circumstances, a handful of needle exchange programmes were initiated in the UK. Later that year a World Health Organisation conference discussed needle exchange as a means of HIV prevention among injecting drug users. In 1987, in the context of a media-led campaign that raised the profile of HIV amongst the general population, the UK government issued directives for pilot needle exchange programmes to be set up and evaluated. A third factor influencing the development of needle exchange in England and Wales was the ascendancy of the philosophy of harm reduction or harm minimisation in the treatment of drug users. Harm reduction can be described as "a social policy which prioritises the aim of decreasing the negative effects of drug use" (Newcombe, 1992, pg.1). The provision of sterile injecting equipment to drug users to reduce the transmission of HIV and other blood-borne viruses such as Hepatitis B and C is an example of a harm reduction intervention.

The government programme of evaluated needle exchange centred around 15 pilot schemes (Donoghoe et al., 1992a). By 1988, these were well established and providing injecting equipment to some drug users, many of whom were not in touch with other drug services (Stimson et al., 1990). The evaluation of these projects is described in Section 1.3. However, early reports were cautiously optimistic about the potential impact of needle exchange in facilitating reductions in sharing injecting equipment among drug users (Donoghoe et al., 1992a).

Also in 1988, the Advisory Council on the Misuse of Drugs produced a report which emphasised HIV as a greater threat to public health than drug use and recommended that resources be given to expand needle exchange (ACMD, 1988). Following this, the Department of Health (DoH) circulated guidelines to health authorities for setting up and running exchange schemes. By the end of 1989, over 120 schemes were running in Britain and the DoH had funded a further series of evaluative studies. Exchange schemes continued to grow and by 1990 there were over 200 in

operation provided by two in three of all drug agencies (Donoghoe et al., 1992a).

Despite DoH endorsement, needle exchange schemes in England were set up with little central government direction. There was a large degree of local autonomy which led to a diversity of service provision, particularly in London (Stimson, 1991). Early schemes, including the service in which this study was carried out, were set up as stand alone sites. However, in the rapid expansion of the schemes most formed part of existing drug services or pharmacies. A variety of other schemes based on mobile, outreach and peer distribution were also initiated (Stimson et al., 1990).

1.3 Evaluations of needle exchanges

The early needle exchange schemes were intensively evaluated. Although set up in response to HIV, the efficacy of needle exchange schemes in preventing the spread of this virus has been difficult to ascertain (Stimson, 1991). Changes in the rates of HIV infection take time to be recorded and causal attributions about the impact of specific interventions are difficult to make. Even if behaviour change is reported among a population, this may not be that which is required to stop the spread of HIV. Stimson (1992a) reports evidence from the United States of a positive correlation between reductions in sharing injecting equipment and a levelling in HIV sero-prevalence, although this could also reflect a saturation of the virus within communities. Hurley et al. (1997) compared HIV rates in cities with and without needle exchange programmes and found an 11% difference in the annual change in HIV infection; HIV infection rates decreased in cities with needle exchange programmes and increased in the cities without them. These studies suggest that interventions, including needle exchange, may have a sufficient impact in facilitating changes in drug users' behaviour to reduce the spread of HIV.

1.3.1 Early evaluations of needle exchange in the UK

The difficulty in assessing the impact of a single intervention on the infection rates of HIV meant that the early evaluations of needle exchanges focused on a number of short-term criteria: how

the schemes operated, whether they reached and retained the targeted client group and changes in HIV risk behaviours among the client group (Donoghoe et al., 1992a). The early evaluations noted that the schemes combined needle exchange with a range of services including advice and counselling on HIV and drug problems as well as other health, social and welfare issues (Donoghoe et al., 1992a). Exchange schemes were also deemed successful in attracting drug users and were regarded as a low-threshold, first point of service contact. For example, 40% of clients in one evaluation had not had contact with another service in connection with their drug use (Donoghoe et al., 1992a).

In the mid 1980s, as many as 70-90% of drug injectors reported regularly sharing injecting equipment (Stimson, 1992a). These figures provide a baseline for evaluating behavioural changes amongst injecting drug users as well as the possible impact of needle exchange. Lower levels of self-reported sharing were noted in clients attending exchanges (Donoghoe et al., 1992b). In the first year of evaluation, 1987 to 1988, 28% had shared in the previous four weeks. From 1989 to 1990 this went down to 21%, one-third of the level found in the UK in the early 1980s. Compared to injecting drug users not using exchanges, clients reported less needle sharing, fewer sharing partners and a longer time period since last sharing. In 1987, non-availability of injecting equipment was the main reason given for sharing. By 1989 this stated reason had dropped from 51% to 19% of the population sample. It is difficult to verify the accuracy of these self-reported changes and there may be some desire in the context of increased awareness of HIV to indicate a change in behaviour. However, the reductions in the rates of HIV infection support the idea that sharing injecting equipment had reduced.

An evaluation was also conducted among the clients of the service in which this present study was carried out (Hart et al., 1989). Rates of reported lending and borrowing injecting equipment fell in attendees (n=133), compared to rates before and during the study. Frequency of injecting did not increase and there was reduced incidence of abscesses, an indicator of use of sterile injecting equipment.

1.3.2 Evaluation difficulties: general changes in drug users behaviour

The 20% sharing rate amongst needle exchange clients in the UK was much lower than in places which did not have needle exchanges, for example 60% in San Francisco (Stimson, 1992a). However, in the UK, reductions in syringe sharing were also found in people who did not attend the exchanges. In both groups, there were low rates of HIV infection (4%) and reduced rates of sero-conversion. Stimson (1992b) suggests that high HIV awareness among injecting drug users, the knock-on effect of needle exchange schemes and increased pharmacy distribution of injecting equipment might all be factors in this general change.

The effectiveness of needle exchange is supported in an international study by Des Jarlais et al. (1998) investigating rates of HIV in cities which implemented comprehensive needle exchange. In cities with a low baseline of HIV, prevalence rates have not increased. However, extrapolations from the high prevalence rates of HIV infection noted in Edinburgh in 1985 have not materialised among UK drug users. In England, outside London, prevalence rate among injectors is less than 1% while in London it is 7%. Over the time needle exchange was developed, injecting drug users, both those in touch with services as well as those outside services, reported changes in their drug using behaviour. The extent to which needle exchange services were significant in these changes remains unclear. Despite this, Stimson (1996) argues that: "a plausible case can be made for the success of public health interventions in averting a potential public health disaster" (pg. 1).

Part of the difficulty in drawing conclusions about the effectiveness of needle exchange from these studies reviewed is the focus of enquiry on rates of sharing injecting equipment and the prevalence of HIV, rather than on processes involved in the behaviour. The following sections consider studies which have attempted to find the determinants of sharing. This begins to reveal the complexity of the behaviour and provides a basis to theoretical perspectives on how needle exchange may impact on drug using risk behaviour.

1.4 Definitions of "sharing"

It is important to define what is meant by "sharing" when discussing injecting behaviour. Epidemiological studies have revealed the complexity of sharing behaviour (Power, 1995a). Syringes, needles, filters, spoons and water supplies may all be shared and use of any of these by more than one person can be defined as sharing injecting equipment. Front-loading or back-loading, where drugs prepared for injection are then distributed from one person's syringe to another, is another form of sharing (Hunter & Donoghoe, 1994). Sharing can also be defined by lending or passing on of previously used injecting equipment as well as borrowing of equipment. The term "sharing" is ambiguous about the direction of sharing and researchers also use the term borrowing (Strathdee et al., 1997). The studies discussed below use a number of definitions which may or may not include the variety of behaviours defined above but all are described in this study as sharing or sharing behaviour.

1.4.1 Associations with sharing injecting equipment

Despite the changes in drug users injecting behaviour indicated in Section 1.3, sharing still occurs. Numerous studies have attempted to understand this. Most use multiple regression analysis, taking the injecting behaviour as the dependent variable and correlating this with various independent variables (Hart, 1996). It is important to note that positive associations or correlations between sharing and a variety of demographic variables described in these studies cannot be taken as causal explanations. Typical studies ask participants to self report retrospectively on sharing behaviour and to complete questionnaires focusing on particular variables, or to list factors that led to sharing. The problem with this type of methodology is that these "reasons" can become explanations. This obscures possible underlying processes and fails to explain the variability of this behaviour across different contexts (Ross et al., 1994). Studies are rarely prospective, testing predictions based on theory, since they are costly and rely on following through a population of people who may be difficult to re-interview over time.

Studies have found that women were more likely to share than men, as were younger drug users and those living with a drug using sexual partner and drug using friends (Myers et al., 1995; Ross et al., 1994; Donoghoe et al., 1992b). Disadvantaged social circumstances have also been associated with sharing (Donoghoe et al., 1992b). Stimson (1992b) notes that globally, areas of high HIV prevalence have high levels of other social problems such as poor housing and unemployment. Hartegers (1990) found that risk reduction is strongly associated with social and environmental factors. Injecting drug users who did not share were more likely to support themselves with paid employment whereas those who shared relied on welfare or criminal activity. Less attainment in education, a history of arrest, current criminal behaviour, unstable housing, or being part of particular minority ethnic groups were also associated with sharing behaviour (Myers et al., 1995; Darke et al., 1994). Attitudes among peers, influence from peers, measures of self-esteem and depression were a further set of associated factors. A recent study found that both male and female drug users who shared were two to three times more likely to have experienced non-consensual sex in their lifetime compared to non-sharers (Strathdee et al., 1997). This study also found a similar increased risk of sharing among men who had sex with men. Gossop et al. (1993) noted that among heroin users, older users, poly-drug use and a greater dependence on heroin were associated with sharing behaviour. Other researchers have found that sharing is correlated with a variety of situational factors, such as using drugs at the point of purchase and being in prison (Stimson, 1991). Intoxication or withdrawal have also been associated with sharing (Ross et al., 1994).

As stated above, these studies should not be read as identifying the causal factors in sharing behaviour. However, they are useful as a basis to form hypotheses and theories about the behaviour as well as assessing the validity of existing health behaviour models. These should be able to account meaningfully for the variance in sharing behaviour noted above if they are to be accepted as valid explanations. Before taking a more general overview of these theoretical perspectives, the following section examines models of health behaviour that have been used to give a theoretical rationale to needle exchange as well as those used to explain the behavioural changes noted amongst injecting drug users in Section 1.3.

1.5 Theoretical understanding of needle exchange and drug using behaviour change

Research has found that injecting drug users are able to modify their behaviour to reduce sharing injecting equipment. There is evidence that sharing is no longer the cultural norm as in the pre-HIV-awareness early 1980s (Donoghoe, et al., 1992b). However, it is difficult to ascertain what the causal factors were in this change. Needle exchange is likely to have been significant in this change, insofar as it is the source for many drug users of injecting equipment, the necessary technological means to inject safely.

Needle exchange is a harm reduction intervention designed to change drug users' injecting behaviour. All health interventions are based on assumptions about behaviour change, whether implicit or explicit. By making explicit these assumptions and their theoretical origins, the processes involved in behaviour change can be better understood and the intervention itself critically evaluated. An examination of the assumptions inherent in needle exchange is therefore a useful starting point to looking deeper at the potential role of this intervention in the injecting behaviour of drug users, which is also the central aim of this study.

1.5.1 "Knowledge" and "means": A theory to understand needle exchange?

Stimson (1989) suggests that needle exchanges were developed in terms of a "knowledge and means" approach to enabling behaviour change. Injecting drug users are provided with *information* about the changes that need to be made (sharing injecting equipment increases the risk of HIV infection) as well as the *means* to change (provision of sterile injecting equipment). Central to the initiation of needle exchanges was the idea that injecting drug users share injecting equipment because it is hard to obtain (the means). As described in Section 1.3, significant proportions of injecting drug users in 1988 were sharing injecting equipment and non-availability of injecting equipment was often cited as the reason for sharing. Poor access to injecting equipment was cited by 55% of clients as their motivation for attending an exchange (Stimson,

1989). Studies also indicated that clients knew that HIV could be transmitted through sharing needles (97% of a sample of 387 needle exchange clients) demonstrating high levels of awareness of the risks of sharing (Stimson, 1989). These figures lend support to the "knowledge and means" model as a means of understanding the impact of needle exchange. However, although changes in the frequency of sharing were noted in clients attending needle exchanges, a minority continued to engage in this behaviour. Stimson (1992a) reports that 21% of needle exchange clients in one study had shared in the previous four weeks. This suggests that there are factors associated with sharing other than knowledge about the risks associated with this behaviour and access to injecting equipment. The "knowledge and means" model may offer a partial explanation of how sharing behaviour changed but does not fully explain why this change occurred or the continued sharing of injecting equipment.

1.5.2 Towards a deeper understanding of the role of needle exchange

That the "knowledge and means" model was thought to be applicable to injecting drug users is an example of a cultural shift in how drug users were understood, particularly in relation to their motivation to change risk behaviour. This shift is indicative of other factors which, if considered, enable a deeper understanding of the potential role of needle exchange in drug using behaviour. Stimson and Donoghoe (1996) argue that health interventions make assumptions about social action, the acquisition of knowledge, the links between knowledge and behaviour and about motivation to change behaviour. The implications of these ideas are that, in addition to providing the knowledge and means to change behaviour, assumptions were made that drug users would be receptive to this public health strategy and would be concerned about and able to make rational choices regarding their health. This reconceptualisation of injecting drug users fits with dominant ideological discourses of the time; health as an issue for individual choice and lifestyle. Although potentially reactionary, in terms of an emphasis on individual agency at the expense of social influence, it is a change from the stereotyped perception of injecting drug users as deviants or hedonists who are only concerned about drug use (Derricott et al., 1999). Des Jarlais and Friedman's study (1988), which found that drug users would change their behaviour to reduce the risk of HIV infection through developing personal strategies, is a good example of evidence that

supported this reconceptualisation of the drug user.

If the "knowledge and means" model is not complex enough to explain sharing behaviour, it is questionable whether it is also sufficient to explain how needle exchange services may work to reduce this behaviour. As mentioned above, needle exchanges were providing a range of other services in addition to the distribution of injecting equipment (Donoghoe et al., 1992). The extent to which these additional components of services may be significant in facilitating behaviour change has not been evaluated. Needle exchange services have also led the way in developing more user-friendly drug services and have often actively involved drug users themselves in the running of these projects (Derricott et al., 1999). This suggests that there is an implicit consideration of issues such as engagement with the client group in how these services operate. The potential importance of these process issues in relation to the complexities of sharing behaviour, a central concern of this study, necessitates a consideration of other theoretical models outlined below.

1.6 Models of behaviour change

A number of models have been proposed to understand health-related behaviour among individuals or groups. Needle sharing can be viewed as health-related behaviour and needle exchange can be defined as a health intervention, although this presupposes certain factors which are discussed below. All health interventions are based on assumptions about health behaviour and behaviour change, some of which have been explored in relation to sharing injecting equipment and needle exchange in Section 1.5.

Models of health behaviour can be broadly differentiated by the extent to which they focus on the individual or on the social context in which the behaviour occurs. These might be understood as representing different levels of explanation. Layder (1993) argues that the problem with the individual / social dichotomy is that the complexity of the processes involved in human behaviour are missed. Human behaviour can be viewed at and across many levels at any one time. Different levels of explanation are also mutually constituted and reinforcing of each other (Layder 1993). In

relation to sharing injecting equipment, a review of the literature reveals a shift over time from models that attempt to understand the behaviour at the level of the individual to those that focus on a social level (Rhodes & Hartnoll, 1996). This shift may be explained by the inadequacy of the individual models to account for sharing behaviour including, for example, the findings of the studies described in Section 1.5. However, critiques of individual models are often made from a social level and vice versa. This does not lead to useful discussion but to circular arguments as to the relative value of a particular explanation.

The following sections describe some individual and social models of health behaviour. These are explored in terms of their theoretical utility and considered in relation to sharing behaviour. This develops an understanding of the ways in which needle exchange may impact on this behaviour.

1.7 Individual models of health behaviour change

There are many psychological models of health behaviour change. These have been used to explain a variety of different health behaviours among different populations. Four models are briefly considered in this discussion; The Health Belief Model (Becker, 1974), The Theory of Reasoned Action (Fishbein and Azjen, 1975), Self Efficacy Theory (Bandura, 1977) and The AIDS Risk Reduction Model (Catania et al., 1990).

1.7.1 The Health Belief Model (Becker 1974)

This model explains health behaviour as a consequence of four perceptions or beliefs. These are:

1. Perceived susceptibility to the illness.
2. Perception of the severity of the consequences of the illness.
3. Perception of barriers to engaging in the health behaviour.
4. Perception of barriers involved in taking action.

Janz and Becker (1984), in a review of 10 years of related research, found significant correlations

with these variables and health behaviour change. A number of methodological issues can be identified in this review which are also relevant to other individual models and are highlighted in Section 1.8. A few critical points specific to Becker's model are outlined below.

Janz and Becker (1984) found the perception of severity of consequences to be less correlated with behaviour change. However, in relation to HIV, regardless of risk behaviour, most people are likely to have a negative perception of becoming infected with HIV. Consequently, perception of severity of consequences would be unlikely to predict risk behaviour or differentiate people who share injecting equipment from those who do not. The perception of severity of consequences forms an important part of knowledge about an illness. In relation to sharing injecting equipment, Klee et al. (1990) found that knowledge of AIDS was not significantly associated with sharing behaviour. Hartegers (1990) also found that risk reduction amongst injecting drug users was only weakly associated with health beliefs but strongly associated with social and environmental factors.

The need to consider factors other than beliefs is also highlighted in the finding that perception of risk of infection of HIV (susceptibility) is not related to condom use (Poppen and Reisen, 1997). The authors of this study suggest that this may be a consequence of the way risk is conceptualised; that it involves a judgment about a sexual partner and will vary with different partners. It is possible that a similar process could occur in relation to sharing injecting equipment. Another issue that The Health Belief Model does not account for is motivation to defend against a perception of risk, which may be usefully understood in psychodynamic terms.

Various elements have been added to the model to increase its utility and predictive power, for example, cues to action (information, experience, anything that triggers a person to engage in the behaviour) and perception of efficacy of treatment (Janz and Becker, 1984). The model also does not sample actual competence or resourcefulness to engage in health behaviour and may simply describe action contemplation. Rippetoe and Rogers (1987) have extended the model to include a self efficacy component as an attempt to account for these factors.

Despite the theoretical limitations of this model in understanding injecting risk behaviour, it bears a similarity to the "knowledge and means" model discussed in Section 1.5, which has been used to explain the theory underlying needle exchange as a health intervention. Whether this is an adequate view of how needle exchange operates is considered throughout this chapter.

1.7.2 The Theory of Reasoned Action (Fishbein and Azjen, 1975)

This model was developed by Fishbein and Azjen (1975). It is based around the idea that intentions to engage in a behaviour lead to that behaviour occurring. Intentions are formed from private attitudes and socially determined subjective norms. Attitudes are formed by beliefs similar to elements of the health belief model: probability and severity of consequences. Subjective norms are formed by perceived social pressure to engage in the behaviour and motivation to comply with these norms or expectations. The theory predicts that a person will engage in a health behaviour if the action is instrumental in achieving desired consequences and is considered worthwhile by significant others.

Elements of The Theory of Reasoned Action have been positively correlated with behaviours such as oral contraceptive use (Jaccard and Davidson, 1972). However, it was originally developed to explain consumer choices and McKirnan et al. (1996) have questioned its relevance to "emotionally charged" areas such as sexual behaviour. Sexual behaviour and sharing injecting equipment are also inherently social activities compared to consumer preference which may be more related to individual decision making. Budd (1987) also found that filling in attitude questionnaires based on The Theory of Reasoned Action led to the formation of attitudes along the lines of the theory, an indication of a problem in determining causality. The Theory of Reasoned Action differs from The Health Belief Model by including a more social element in the form of subjective norms. However, there is limited indication of how these norms initially develop and it is assumed that they lead to intentions that are then translated into the appropriate behaviour.

1.7.3 The Theory of Self Efficacy (Bandura 1977)

Bandura (1977) developed a theory based on the idea of self efficacy as a general way of understanding behaviour change. Self efficacy is an individual attribute and refers to the conviction a person has that he or she can successfully execute the required behaviour to produce a particular outcome. This can be criticised as a form of cognitivism. It does not address how efficacy expectations are initially formed or account for the possibility that they may shadow behavioural success rather than precede it (Miller, 1998). Despite this, the concept of self efficacy has been included in models of health behaviour to increase their predictive power, including that outlined below.

1.7.4 The AIDS Risk Reduction Model (Catania et al., 1990)

This was developed by Catania et al. (1990) as a sequential model of the psychosocial processes that occur in HIV risk behaviour change. The model integrates constructs from the three theories outlined above. Behaviour change occurs in three stages:

1. Labelling behaviour as problematic.
2. Forming an intention to change behaviour.
3. Taking action to accomplish change.

Progress from one stage to the other depends on cognitive factors such as perception of social support and the costs and benefits associated with behaviour change. A study by Longshore and Anglin (1995) of HIV negative drug users (n= 159) who had shared injecting equipment in the previous year aimed to test empirically this model. Although constructs from the model were related as predicted, for example perception of infection risk to HIV knowledge, there were also a number of inconsistent results. For example, there was not a relationship between self efficacy and risk reduction. Drug users with peers who engaged in lower risk behaviour were also less likely to intend to make any reductions in sharing injecting equipment. This indicates the need to consider the processes and interactions between individual beliefs, peer norms and behaviour.

1.8 Critique of individual models of health behaviour

The models discussed have difficulties accounting for variability in health behaviour and are based on studies which have methodological limitations. Many utilise a retrospective research design leading to problems determining the direction of causality between beliefs and behaviour.

1.8.1 "Health" as a reified construct

All the models described assume that health behaviour change is a consequence of individual beliefs and make an assumption about rationality in response to knowledge about a potential health threat. For health professionals it is easy to assume that the concept of "health" is a valued and understood construct, reifying it as an individual attribute or trait. However, there are poor correlations among preventative health actions suggesting that there is not a unitary orientation towards health (Becker and Rosenstock, 1984). People may engage in health related behaviours for reasons that are not related to a "health" construct. These may be habitual behaviours, such as brushing teeth, or those that gain social approval, such as dieting. These models also suggest that, once formed, health related beliefs are stable over time. However, it has been demonstrated how peoples' beliefs are subject to variability across different contexts (Abraham and Sheeran, 1992). In terms of injecting risk behaviour, the models do not account for the function of injecting which is to ingest drugs and alter a state of consciousness. In the context of poor availability of sterile injecting equipment, using drugs may take precedence over maintaining behaviours congruent with health related beliefs.

1.8.2 Social influence and individual behaviour

Generally the individual models can be criticised for focusing on cognitions at the expense of other variables that may be related to behaviour change. This is a point often made by theorists and researchers who are more orientated to a social level of explanation (Rhodes and Hartnoll, 1996). Although it is argued that this can lead to dualistic, either/or arguments about the relative worth of different levels of explanation, the criticism is valid, particularly in developing a richer

understanding of health behaviour. The individual models do not account for the social nature of many health behaviours or address the impact of structural factors such as poverty on health behaviour. Clearly, health behaviour and individuals' cognitions regarding their health are situated within, and therefore mediated by, socio-economic, political and cultural influences.

In relation to gay men and sexual risk activity, Hart (1996) suggests that individual models ignore three broader influences on health behaviour: first, the context and circumstances of the sexual encounter, including with whom sex takes place; secondly, the relationship of power in the sexual encounter and, thirdly, the broader socio-cultural context of the behaviour. All these points are also relevant to sharing injecting equipment. Stimson and Donoghoe (1996) write that individually orientated approaches do not take into account that group membership is of significance in determining risk exposure by ignoring the communal aspects of the behaviour; sharing involves an interaction between at least two people. When sharing occurs, it is often with sexual partners, close friends or in the context of specific social circumstances. Power differentials may exist in a drug using situation and could affect sharing. For example, the dealer or buyer of drugs may have or be perceived by others involved to have more power in a drug using situation. Finally, from a wider socio-cultural context, drug users are a marginalised and stigmatised group that often need to keep their illegal behaviour discreet and hidden. This may impact on individual behaviour in a number of ways including how services are utilised.

Social factors can also facilitate or constrain individual behaviour and group norms about sharing behaviour. These can be structural factors such as economic constraints (having money to buy injecting equipment), homelessness (a place to keep equipment and inject) both of which have been correlated with sharing (Stimson, 1992). Similarly the circumstances within which drug use occurs may facilitate or constrain individual behaviour. Burt and Stimson (1991) found that sharing was not a normal drug using behaviour and when it did occur was due to exceptional events. Ross et al. (1994) suggest that availability of injecting equipment is effective only if it extends to the time and place of the injection. Other studies have found that injection is most likely to occur later in the day or at night when most needle exchanges are closed (Gossop et al., 1993). Taking these findings together, it is possible to see how situations could develop where

sharing might be likely to occur which has little to do with individual beliefs about health behaviour and within these circumstances may be "rational" (Stimson, 1992b).

Ethnographic studies indicate that structural and cultural influences may play a role in sharing and epidemiologists have shown that there is considerable variation in the prevalence of HIV infection among drug injectors in different countries, in neighbouring cities and even in neighbourhoods in the same city (Stimson, 1992b). These variations suggest that it is important to look closely at local conditions, patterns of drug use and cultural influences in the way drugs are used. Although it is individuals who become infected with HIV, it does not follow that the reasons for this can be found within that individual (Stimson and Donoghoe, 1996). However, individual models have been influential in the way health behaviour is viewed. Stimson and Donoghoe (1996) argue that the dominance of individual approaches is a consequence of the "individualisation of public health through health promotion" (pg. 19). They argue that there has been a historical shift in public health efforts, from collective measures to change the environment within which people had little influence, to a model of individualism and health. This cultural shift occurred at the time needle exchange programmes were developing and may be why this intervention is so closely tied to an individual model of health behaviour change.

The limitations of individual models are that they fail to account adequately for the complexity and variability of health behaviours. Health behaviour is not only an individual action but one which takes place in a social context. These contexts can constrain or enable individual behaviour. In the following sections social models are considered.

1.9 Social models of behaviour change

Interventions to reduce risk behaviour among drug users at a group or network level have recently been proposed as the way forward (Rhodes, 1996). Rhodes suggests this because of the theoretical limitations of the individual models, the limitations of the consequent interventions, the difficulty of reaching groups of drug users who do not use services, the continued sharing behaviour of injecting drug users, the lack of changes in sexual risk behaviour, evidence of

contextual and situational factors in determining sharing behaviour and the role of social networks in sanctioning behaviour. Power (1996) also notes a move towards a more social perspective, due to research findings, critiques of outreach work and existing service provision that is too closely focused on the individual.

There are three broad areas that have been researched and used as a basis for developing interventions. These are social norms, social contexts and social interaction (Hart, 1996). Clearly all these overlap and interweave but are discussed in turn.

1.9.1 Social norms

There are a number of models that focus on social norms or culture as significant in health behaviour change. Underlying these models is the idea that there must be social consensus of the desirability of behaviour change for it to occur. An example of a social process model is The Diffusion of Innovation Model (Rodgers 1983). This and related peer education interventions are critically described below.

1.9.1.1 The Diffusion of Innovation Model (Rodgers 1983)

Developed by Rogers (1983), the theory suggests that social norms can be successfully introduced through a community when endorsed and communicated by key people in a network. Hart (1996) reviews studies where interventions based on this model have been effective in helping gay men reduce sexual risk. A problem of this model is that it is unclear what the processes are that lead to actual behaviour change. How and why does endorsement of safer sex by a popular figure in a community lead to behaviour change among others in that community? Not all individuals conform to group norms and there is a danger of making causal assumptions about the impact of these norms in much the same way that assumptions are made about individual beliefs and behaviour. A further difficulty is that this model implies certain assumptions about communities, i.e. that they exist and are cohesive, share a common purpose and values. Many gay men identify themselves with the gay community as an important part of their self-

identity but this may change over time and there are men who do not identify with this community but still have sex with men. An intervention to reach these men would have to take into account different factors from that designed to impact on people within a community. It is also questionable, as is the case with drug users, whether men who have sex with men outside a gay community could even be accurately described as a community. Using the idea of community as a means to demarcate and intervene with people on the basis of their behaviour is a potential trap that researchers and interventionists could fall into and brings into question the relevance and potential efficacy of some interventions to change social norms.

1.9.1.2 Peer education

Stimson (1996) calls for facilitating changes in communities or populations of drug users and argues, for example, that clients of needle exchanges should be actively involved in promoting behaviour and attitudes in their community so that not sharing becomes the norm. Peer education projects have been proposed to achieve these changes (Rhodes, 1993). Although peer intervention projects are often about the dissemination of information or actual injecting equipment to a "hard to reach group" they are also about changing social norms in relation to drug using behaviour. The issues raised in the preceding section also apply to the uncritical adoption of peer education as an alternative to the limited impact of individual interventions. A further difficulty with these projects is lack of consideration of factors that may constrain a sense of community among drug users.

1.9.2 Social contexts

Reports from the US have noted the importance of social conditions and sharing behaviour in the spread of the HIV virus. For example, Watters (1989) compared the high levels of HIV in New York with the relatively lower levels in San Francisco. He suggested that this difference could in part be attributable to shooting galleries being a significant part of injecting drug using culture in New York, in which a number of people frequent and share rented equipment. In contrast, people in San Francisco shared within small friendship circles with less contact with a wider network.

Whether the varying incidence of HIV can be attributable to the different contexts of using, differences in context may determine how people interact and who with, which may influence the development of social norms around drug using behaviour. It has been shown that drug users are more likely to share injecting equipment when using away from home (Darke et al., 1994). Latkin et al., (1994) also found that, although most people injected at home, when injecting at a friend's house, in shooting galleries and in semi-public areas, they were more likely to share injecting equipment. They suggest that this is due to the individual having less personal control over circumstances and a consequent unwillingness to differ from social norms in these contexts.

Although poor availability of injecting equipment is a frequently cited reason for sharing behaviour, always within a "context", there is a difficulty in establishing causal relationships between context and behaviour. A number of processes might mediate sharing behaviour in specific contexts. The study by Latkin et al. invokes various social psychological ideas but these are not then empirically tested. Context might constrain or enable behaviour in a number of ways but, within this, behaviour will also be mediated by individuals' beliefs and their interactions.

1.9.3 Social Interactions

In the following sections, social interactions are considered in terms of sexual relationships and gender, social networks and social support as influences on injecting risk behaviour.

1.9.3.1 Sexual relationships and gender

Ross et al. (1994) report significant levels of sharing injecting equipment between sexual partners. Sharing may be related to feelings of trust in intimate relationships and beliefs that, if there has been unsafe sex, infection is inevitable and sharing will not increase this risk (Darke et al., 1994). These authors also report that women who inject drugs are more likely to share than men. Women are also twice as likely to have an injecting sexual partner than men, so there is more risk of sharing in the social context of their drug use (Darke et al., 1995).

Bloor et al. (1992) found among male prostitutes that personal control over condom use was constrained and emergent from the context of the behaviour. There are also differences in power within sexual relationships. Although the concept of power needs to be carefully considered, Rhodes and Quirk (1996) suggest, in relation to safer sex, that women may not have as much power as men to make the necessary choices to engage in this behaviour. The experience of power in relationships may also be seen as another mediating factor in whether sharing injecting equipment occurs.

1.9.3.2 Social networks

Power (1995a) identifies the social networks of drug users as an important focus of intervention. The link between drug users, whether social or spatial, centres around the consumption and purchase of drugs, necessitating communal activity and engagement with others. Power's study suggests the need to maintain a supply of heroin bound users together in networks. Certain rules operated within these networks so, for example, being too chaotic led to exclusion from the network. It was noted that information relevant to risk reduction was disseminated informally through a network within the context of buying and selling drugs. Power also reported that risk management was part of drug users' daily routines: for example, buying drugs in small quantities and maintaining a supply of clean injecting equipment. He suggests that community interventions could successfully build on existing strategies.

The study also found social factors that were related to sharing. These included being in a sexual relationship with another injecting drug user and being in situations where injecting equipment was scarce. Injecting paraphernalia such as filters and spoons were shared and perceived to be of low risk in one network and etiquette determined that filters, because of drug residue, were left behind at the home of the person where drugs were used as a form of payment. This study highlights the connections between social norms, context and interaction. Although Power (1995) argues that ultimately risk management operates at the level of the individual, an awareness of the social nature of drug use indicates points where social factors enhance or constrain these strategies. This information is then useful in developing specific and potentially more effective

interventions.

It is important to note that assumptions about one network should not be made about another. Power's study describes particular networks but these may vary in different regions and around different drugs. Power's work outlines a more dynamic quality to risk behaviour and strategies adopted to reduce risk. There is an interplay between the individual and his or her network. This study also outlines how good qualitative research can develop an understanding of drug using risk behaviour in specific contexts.

A report by Edmunds et al. (1996) of various drug markets, including one near the service which this study investigates, provides invaluable ethnographic information and illustrates how a social context may impact on the quality of the interactions within it. The market near the service studied in this research is defined by Edmunds et al. as open rather than closed because it is readily accessible to potential buyers of drugs. Open markets are risky places and, because of the illegal activity, crimes can occur against the users of the market without intervention from the police. The authors of the report suggest that open markets are therefore "beset by problems of trust" (pg. 3). Being mugged for money or drugs was common. More specifically, the market around the service was defined as specialist, catering for long-term drug users and the supply of drugs for the market was as a consequence of overspill from private prescriptions of injectable methadone and other pharmaceutically produced drugs. Unlike other markets studied, where heroin was the principal drug traded, regular relationships with sellers did not need to be established as the quality and availability of pharmaceutical drugs was consistent. Sellers of drugs may also become buyers of drugs once their prescription had run out. Therefore, there did not appear to be a hierarchical structure to the market. These descriptions of the market around the service studied indicate a number of factors that could define the quality of the network of drug users using this market. This study also aims to explore the quality of these interactions. By contrasting the description of the market around the service with Power's (1995) study of heroin using networks, clear differences emerge. This suggests the importance of detailed knowledge about the specific structure of drug using networks as a precursor to intervening at this level.

1.9.3.3 Social support

Social support has been investigated as a potentially significant factor in people's health, although not extensively in relation to drug users (Orford 1992). Various models have been proposed to explain the relationship between support and health and, although defined in terms of social interaction, they remain focused on individual's and their behaviour. In this sense, research in this area can be seen as attempting to understand interactions between individual and social levels of explanation.

Research has found strong correlations between social support and positive outcomes for health (Cohen and Syme, 1985). Two theories have been proposed to explain this association (Stowe et al., 1993).

1. The direct effect model proposes that social support gives people positive experiences and a socially rewarding role which enhances health and wellbeing through, for example, raising self-esteem. This can then positively influence behavioural and physiological responses in relation to illness susceptibility. This model could be relevant to maintaining safer injecting behaviour; support maintains a sense of self-esteem which may increase the likelihood of maintaining safer drug use.

2. The buffering model, in contrast, proposes that it is the resources provided by others that protect people from the negative impact of stress. Support reduces the harm of a stressful event or raises self-esteem so that the event is not recognised as stressful. Buffering support may also influence positive behaviour in relation to illness. Research with HIV positive gay men, has shown that social support mediates the stress associated with being HIV positive (Stowe et al. 1993). While these studies conceptualise health in terms of physical wellbeing and refer to adjustment to a known health risk, the concept has potential relevance to maintaining and initiating behaviours that may impact on health. Drug users are often stigmatised as a consequence of their behaviour (McDermott, 1992). This can lead to alienation from social support structures, increase anti-social behaviour and decrease the likelihood of using services.

Stigmatised status may magnify the impact of life events. In this context, it is important to understand the extent of social support among injecting drug users and the potential this has for reducing drug-related harm.

Stowe et al. (1993) investigated the extent of social support among injecting drug users (n=100). They found that drug users have support networks but that friends are perceived to be more important than family. However, there were some difficulties in this study operationalising concepts such as "emotional support" and the researchers felt that there were considerable differences in participants' perception of a "close friend". This study did not explore possible connections between social support and risk behaviour, although Havassy et al. (1991) found a positive association between support and drug treatment outcome.

These studies indicate the considerable difficulties defining social support and the inherent subjectivity in how different people understand the meaning and experience of interactions with others. Orford (1992) in his review of social support literature writes that the functions of support may be;

1. Material
2. Emotional
3. Informational
4. Related to esteem
5. To provide companionship.

This description of the functions of social support operationalises the concept to some extent. It also offers a potential framework to evaluate "supportive" interventions. Orford (1992) notes that people defined as having chronic problems, including drug users, are often neglected in social support research, which tends to focus on life events as opposed to chronic problems. He also suggests that the type of support which people may require may vary depending on their needs. For example, when people are in a crisis they may require more emotional based support, but when they are making a change in their behaviour may benefit more from informational support. This suggests that there is a need to match the type of support to individual's needs. Finally,

Orford suggests that professionals can play a useful part in relation to support. This is explored further below.

1.9.3.4 Support from staff in drug agencies

Stimson and Donoghoe (1996) write that, before AIDS, drug workers were concerned with drug users minds, not their health behaviour. The ascendancy of harm reduction has changed relationships between client and staff. Drug workers adopt symbols of closeness and similarity which is a move away from symbols of professional dominance and distance. This is particularly true of outreach workers and services not directly involved in drug treatment such as needle exchanges. This change must partly relate to assumptions about the salience of interventions in the context of interaction and may be usefully understood in terms of client satisfaction and the quality of the therapeutic alliance.

Satisfaction with services has been shown to have an impact on compliance with health care strategies and a friendly and understanding manner from the professional (Smith and Ley, 1987; Ley, 1988). Therapeutic alliance, defined as a trusting and collaborative relationship, has been shown to impact on therapeutic outcomes. Tunis et al. (1995) explored alliance between clients of a methadone programme, their peers and staff. Higher levels of counsellor alliance were associated with less frequent needle sharing. However, higher peer alliance was associated with more sexual risk. This suggests that support from professionals, as opposed to peers, may be a factor in risk reduction. Support from drug users where sharing is the norm could also be a barrier to risk reduction.

Research on counsellor and client interactions has informed the development of motivational interviewing, a counselling approach designed to maximise the likelihood of behaviour change (Miller and Rollnick, 1991). A central principle to this approach is that motivation to change behaviour is determined by the interpersonal interactions between counsellors and clients. Motivational interviewing defines an approach which allows clients to explore the possibility of behavioural change in the context of a supportive and non-confrontational counselling style. The

concept of motivation is considered in more detail below, but in the context of the functions of social support is a good example of an applied theoretical approach that draws on psychological and social theories of behaviour change.

1.10 Critiques of social models of health behaviour

Social models inform interventions that aim to facilitate changes at a wider level within communities, peer networks and specific contexts. Norms defined within these social groupings are considered to be a major influence on an individual's behaviour. In contrast to the individual models discussed, groups of individuals and relationships are the agents of change (Rhodes, 1996). Rhodes and Quirk (1996) write that many socially orientated interventions have an overly simplistic understanding of how social norms influence behaviour. As individuals deviate from norms there needs to be caution in assuming that there is a consensus as to what constitutes risk behaviour.

Rhodes and Quirk (1996), in a review of their work on sexual behaviour among heroin users, suggest that HIV risks are relative concerns. Health risks associated with sexual behaviour are often viewed as less important than the risks associated with drug use. They suggest that this difference illustrates how risk perception is a "socially situated phenomenon" (pg. 167) and that the norms and routines of lifestyle shape perceptions of risk acceptability. As mentioned above, risk behaviour may be more about habit than individual decision making. This research indicates that there are everyday norms among drug using networks that encourage safer drug use. Placed in a historical context these have changed in the last 15 years. Rhodes and Quirk write that safer drug use occurs because it is normal and that unsafe sex also occurs because that is also normal among drug users. This appears to be a circular argument and does not explain the processes by which these norms arise. However, there are differential norms about risk which vary in different social and situational contexts.

1.10.1 Concepts of power and powerlessness

People do deviate from safety norms evidenced by the continued occurrence of sharing behaviour. This still does not explain the process by which social norms change over time. Rhodes and Quirk (1996) suggest that norm changing strategies will only ever be partially effective. One factor that may be overlooked is power differentials in interpersonal interactions which may influence how safer behaviour is negotiated. Choices are linked to specific social contexts in which action occurs. This suggests that choice is relative, often a product of group norms as well as unevenly distributed among individuals. Rhodes and Quirk use the example of an individual's sexual safety being constrained by actions of other individuals, suggesting that social norms about gender impact on women's relative power and ability to exercise choice in these situations. Choice is therefore unequally distributed by gender.

The concept of power and powerlessness has been understood not only at a social level. Orford (1992) invokes the concept as a key part of a developing theory of community psychology. Powerlessness can be understood in relation to the feeling of personal control one has over events. From Orford's perspective, powerlessness is determined by both environmental and personal (individual) factors. As noted above, injecting drug users are likely to be marginalised, stigmatised and possibly excluded from social structures and supports because of wider cultural beliefs and attitudes, some of which are determined and enacted by laws and policies of social control. Within this cultural context, injecting drug users may be vulnerable to the experience of powerlessness and this may be important to consider in relation to sharing behaviour.

Powerlessness is also manifest at a psychological level and this may provide a possible theoretical explanation to the associations between low self-esteem, low mood and experience of sexual abuse with sharing behaviour (Strathdee 1993). Orford (1992) writes that powerlessness is determined by both social and individual factors and importantly the interaction between these factors. Social theories by their focus at this level of explanation may lose sight of other useful explanatory concepts from the individual level. For example, norms among peers influence the extent to which a particular individual behaviour is likely to occur. It is more acceptable to behave

within group norms requiring less rationalisation and perhaps creating less dissonance. This is a psychological concept and demonstrates that, although social norms may constrain individual behaviour, it is necessary to consider individual action within this context. This would lead to interventions such as enhancing strategies to make choices in the context of particular group norms. Interventionists need to be realistic about the potential impact of norm changing strategies and the utility of a totally social model of risk behaviour.

1.10.2 Psychosocial interventions

Ideas from community psychology are useful in drawing together ideas from both the social and psychological levels of explanation (Orford 1998). An example of the application of these theories is Sue Holland's (1992) work. Her study describes a project with women who were experiencing depression. The intervention started with individual psychotherapy, but moved to group work and finally into social action. Thus the women involved understood their initial and psychologically experienced distress in terms of social contexts and structures and were collectively empowered to address these issues directly and to counter their feelings of powerlessness. The importance of this project is its example of placing psychological factors within a social context, to draw out the connections between individual and social experience.

1.10.3 Concepts of drug using communities: Issues to consider

A further difficulty with social models is an assumption that drug using networks are cohesive enough to define a set of normative behaviours. Drug users group together as a function of their drug use. Relationships obviously emerge between individuals but the networks are defined by the functional needs of the lifestyle (Power, 1995b). Relationships are often characterised by mistrust and friendships are often based on smaller networks of two or three people (Rhodes, 1996). The illegality of drug use adds to a notion of individualism in drug using groups that may act against systems of collective support and reduce the potential impact of interventions to change group norms. The notion of community may extend only as far as purchasing drugs so that there is not a shared sense of social, political identity acting as a framework for change as

there has been in the gay "community" (Rhodes and Quirk, 1996). This raises the possibility that informal networks of drug users may not be suited to collective action or promoting behaviour change.

Relating this point to Holland's (1992) work, part of her project was enabling women to form a collective voice and understanding of their distress and difficulties, locating the determinants of this at a social level. Similar ideas are emerging through drug user forums which attempt to form a collective voice to challenge oppressive policies and laws. This is in evidence, for example, at the meetings and forum provided by the International Harm Reduction Conferences (1999). The potential role of these organisations in changing cultural norms around sharing is only just beginning to be explored. Clearly, involvement of drug users is likely to be important in accessing other users and creating a more cohesive supportive culture. But the impact of peer education projects is likely to be limited by the same factors that constrain individual behaviour change. It is important to acknowledge powerful constraining factors that militate against drug users forming a collective voice.

Social models and assumptions about drug using communities fail to explain fully how social norms influence individual behaviour and how these social norms may be changed. As suggested earlier in this review a fundamental difficulty is a narrow focus on a single level of explanation. Essentially a more integrated social / psychological model is required. It is important to understand how individual behaviour can be constrained by situational and social contexts. Some theoretical models and interventions have developed promising new ways of working to reduce risk behaviour among target groups. But the processes by which changes occur has not been adequately explained. A danger in shifting the research gaze from the individual to a wider social level is that the individual within a social context becomes lost. At its worst this can lead to causal assumptions about structural factors and risk behaviour and uncritical assumptions about the validity and impact of more social interventions. Although the individual models have been found to be lacking, the extent to which they have been operationalised for research purposes has been not matched by the social theories.

This literature review indicates that it is necessary to move beyond a simplistic view of risk behaviour as one that occurs at the level of, or is a consequence of either individual or social factors. Sharing injecting equipment occurs for a multiplicity of factors which vary across time as well as within populations of drug users. In the following section the concept of motivation is discussed as a potentially integrative concept to incorporate ideas from both social and individual levels of explanation.

1.11 The individual in context: Motivation as an integrative concept

Both individual trait models and social theories have some value in understanding the behaviour of sharing injecting equipment. To move this discussion away from a dichotomous debate about the value of a focus on a particular level of explanation, the concept of motivation as a potentially integrative concept is proposed. Some idea of motivation is implicit within the individual and social theories discussed. For the purposes of this discussion, a definition of motivation is adapted from the theoretical basis to motivational interviewing (Miller and Rollnick, 1991). Motivational interviewing is a counselling approach broadly based on self regulation theory and draws on strategies from client centred counselling, cognitive therapy, systems theory and social psychology. It is apparent from this variety of influences that it is based on ideas from across individual and social levels of explanation. Motivation in this theory is not a trait, but a state of readiness to change which may fluctuate from one time or situation to another. Motivation is defined by Miller and Rollnick as "the probability that a person will enter into, continue, and adhere to a specific change strategy" (pg. 19). It is a *behavioural probability* which is moderated by a number of different influences. Motivation depends upon context and, within this, interactions between people. In this sense it is socially determined as opposed to an individual attribute or internal state. Individual values and beliefs are significant in this concept of motivation although they are defined through interaction and by a variety of social influences and within specific contexts.

1.11.1 Ambivalence as competing contingencies

A key concept within this definition of motivation, which draws out its integrative potential, is ambivalence. As with motivation, it is easy to reify ambivalence as a trait or construct, however, Miller (1998), in terms of operant conditioning theory, defines ambivalence simply as simultaneous competing contingencies. Although Miller suggests these "logically lie within the individual's intrinsic motivational structure" (pg. 168), I argue that these contingencies could be both individually and socially determined. While the concept of costs and benefits that Miller invokes suggests an inherent rationality to resolving the state of ambivalence, I would stress that the perception of these is constructed within a social context and therefore mediated by social and cultural forces. This would account for behaviours that are enacted non-consciously as "habits". Ambivalence therefore fluctuates and a variety of factors that could be located within individual and social levels of explanation may be significant in this process and usefully considered in terms of competing contingencies.

A simple example and a potential contingency in relation to sharing behaviour is the attachment to drug use itself. This may be understood as pharmacological dependence, a learned response to cope with aversive psychological states or a key part of a social activity (Liese and Franz, 1996: Toneatto, 1999). The function that the drug use serves may then be considered as a competing contingency to safer drug using peer norms or individual beliefs about safer injecting. In a drug withdrawal state, associated with sharing (Ross et al., 1994), the salience of these beliefs may be heightened and in the context of poor availability of injecting equipment increase the possibility of sharing occurring.

All the models and theories discussed may offer partial explanations as to what the contingencies related to sharing behaviour may be and the particular salience of these factors may vary between and within individuals and situations over time. This broad and fluid conceptualisation of motivation draws together the potential value of each of the theoretical positions discussed. It highlights how sharing behaviour will be determined by a multiplicity of factors. This does not provide a simplistic resolution to understanding sharing behaviour as it is based around

integrating ideas from a variety of sources at different levels of explanation. As well as being useful in terms of theory, motivation is also integrative in terms of practice. Motivational enhancing strategies have gained widespread acceptance as valid clinical interventions (Miller, 1998). In the following sections the issue of behaviour change is considered from the perspective of interventions and processes associated with change occurring. This provides another way of thinking about how a service may be in a position to effect change among its clients.

1.12 Motivation and interventions to change behaviour

Understanding motivation in terms of a behavioural probability indicates that the goal of an intervention is to increase the probability that this behaviour occurs. Miller and Rollnick (1991) outline counselling strategies which are designed to increase motivation. They draw upon Rogerian client centred skills as the cornerstone of their approach and identify eight strategies which have shown to be related to change occurring. These are outlined below.

1. **Giving advice.** Identification of problem area. Explain why change is important. Advocate for change.
2. **Removing barriers.** Providing the technologies, e.g. injecting equipment. Cultural appropriateness.
3. **Providing choices.** Enhance freedom and responsibility in relation to change.
4. **Decreasing desirability.** Increase awareness and salience of adverse consequences of behaviour.
5. **Practising empathy.** Associated with lower levels of resistance and greater long-term behavioural change.
6. **Providing feedback.** Information re: consequences of behaviour.
7. **Clarifying goals.**
8. **Active helping.** Actively expressing care and an interest in the change process.

These eight strategies described by Miller and Rollnick are useful to consider in terms of interventions to change behaviour. To take a different perspective, the consequences of these

interventions can be seen in relation to Bilsen's (1991) ideas about motivation. He suggests that people are likely to change their behaviour if they understand how their problems may be related to their behaviour (knowledge) and are concerned about this (concern), but at the same time feel positive about themselves (self esteem) and able to make this change (competence). These four elements can be seen as a set of cognitions that may increase the probability that behaviour change will occur. The eight strategies outlined above can be seen as enhancing these four aspects of motivation. Although Bilsen's model of motivation is very similar to the individual health models described in Section 1.7, the determinates of these elements could be social and vary in different contexts. To link Bilsen's and Miller and Rollnick's ideas to a more social perspective, they bear some similarity to the functions of social support described by Orford (1992). These are material, emotional, informational, related to esteem and companionship.

1.13 Processes associated with behaviour change

A further way of looking at behaviour change, including injecting risk behaviour, is in terms of processes associated with behaviour change. Prochaska et al. (1992) report a number of processes that predict behaviour change. These are placed in Prochaska and DiClemente's (1986) stages of change model. This is based around five stages which people move through when changing an (addictive) behaviour.

These are precontemplation, contemplation, preparation, action and maintenance. Table 1.1 outlines the stages of change with the relevant process associated with an individual moving from one stage to the next.

Table 1.1[1] **Stages of change and processes associated with change**

Precontemplation / contemplation	Contemplation / preparation	Preparation / action	Action / maintenance
Consciousness raising - increasing information about self and problem **Dramatic relief** - expressing feelings about one's problems and solutions **Environmental reevaluation** - assessing how one's problems impact on the environment	**Self-reevaluation** – assessing how one feels and thinks about oneself with respect to a problem	**Self-liberation** - belief in ability to change, making a commitment to change	**Counter-conditioning** - substituting alternatives for problem behaviours **Stimulus control** - avoiding stimuli that elicit problem behaviours **Reinforcement management** - rewarding oneself for changes, being rewarded by others **Helping relationships** - being open and trusting about problems with someone who cares **Social liberation** - Increasing alternatives for non-problem behaviour in society - community action

Although the authors do not specifically address behaviour change in terms of motivation, there is a congruence between some of these processes, Bilsen's four motivational elements and the eight strategies outlined by Miller and Rollnick, particularly in the precontemplation to action stages. However, if the processes in the maintenance stage are thought of as competing contingencies to substance use, these too can be considered in relation to motivation. Each of these processes is about avoiding stimuli associated with substance use or developing alternative reinforcing behaviours. This is important to consider since evidence about injecting risk behaviour indicates

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[1] Adapted from Prochaska, J.O., DiClemente, C.C., Norcross, J.C. (1992) In search of how people change: Applications to addictive behaviours. American Psychologist, 47, 1102-1114.

that it can fluctuate within individuals and across different contexts (Burt and Stimson, 1991; Ross et al., 1994). Strategies to maintain this behaviour are likely to be as important as strategies to change risk behaviour. Many of the processes identified in the study by Prochaska et al. are also social in nature, involving interaction with others. In particular, social liberation may be indicative of the processes that Holland (1992) attempted to facilitate in her study. This work can therefore be seen as identifying social/psychological processes associated with behaviour change and offer a further way to think about how a service may impact on a behaviour such as sharing injecting equipment.

In the next section, I propose an explanatory framework within which models, processes and interventions associated with injecting risk behaviour and from different levels of explanation may be considered.

1.14 A framework to understand sharing behaviour

It is apparent from the ideas presented in this chapter that there are many different perspectives on the possible determinants of sharing injecting equipment. To draw these ideas together it is necessary to take theoretical perspective that includes those from different levels of explanation and disciplines. Rhodes (1996), to explain sexual risk behaviour, suggests that there is an "interplay between the intentions of individuals, their interpersonal interactions and social norms which regulate communication and behaviour in sexual encounters". (pg. 170). This is a good example of an attempt to take a multidimensional view of a behaviour. Smail (1990) also writes about the importance of placing an individual in a social context. He stresses that an individual's psychology is determined by his or her interaction with the world. The environmental influences that operate on individuals can be understood as proximal influences, which include family and work, and distal influences which include culture, class and ideology.

The framework I propose is based on Layder's (1993) research map within which a range of influences on the behaviour of sharing injecting equipment can be conceptualised. The purpose of this framework is threefold. First, no single theory has been sufficient in explaining the complexity

of processes involved in injecting risk behaviour. A multitude of factors may be significant for risk behaviour to occur both within individuals, between individuals and within social groups. These may all vary across time and context but may be usefully understood in terms of motivation and competing contingencies. Secondly, it is not the purpose of this review of the relevant literature to resolve the various theoretical arguments but to suggest that each may represent a valid but specific layer of reality. Within this conceptualisation, both individual and social models of behaviour change may be useful in understanding injecting risk behaviour and are not seen in opposition to each other. Thirdly, the framework can be used to generate questions and to explore the ways in which a needle exchange service may function to reduce injecting risk behaviour.

The framework consists of a number of elements: the self, situated activity, setting and context. Most of the research in this chapter refers to a single element of this framework. The value and relevance of Layder's approach is that the elements are seen to be closely interrelated, they are both interdependent and mutually constituted. The self refers to an individual's sense of identity and perception of the social world. But a behaviour such as sharing injecting equipment also occurs within a socially defined situation and within specific settings and contexts. The following framework describes each level and places some of the theory and research discussed in this chapter to illustrate each level.

Table 1.2 A framework to understand sharing injecting equipment

Level of Explanation	Theory
Context or distal influences. Culture, class and ideology	**Social policy and discourse:** Substance use control, treatment options Harm reduction policies
Setting or proximal influences. Institutions, structures, geographical position	**Social contexts:** Drug using networks Drug markets
Situated activity. Social Interaction	**Social norms:** Diffusion of Innovation Model Peer education **Social interactions:** Peer norms Social support Counsellor / client interaction and motivational enhancement strategies
Self. Individual	**Psychological models:** Health Belief Model Theory of Reasoned Action Self Efficacy Theory **Psychological mood states**.

Each of these levels defines competing motivational contingencies which may determine the drug using behaviour among individuals and groups of drug users, over time and across different situations. In the final section of this chapter the utility of this framework in understanding how needle exchange may function to increase the likelihood of safer injecting is considered.

1.15 Needle exchange as a health intervention - a theoretical reconsideration

The framework outlined can be used to reconsider how needle exchange may operate to reduce injecting risk behaviour. As highlighted in this chapter, needle exchange as a health intervention is based on assumptions about why drug users share injecting equipment and how they might change this behaviour. It has been suggested by researchers that needle exchange is based on a "knowledge and means" approach to reduce sharing behaviour. This model has been shown to fail to capture the complexity of sharing behaviour and to make overly simplistic assumptions about how behaviour change occurs. Using the framework to think about this model helps to understand the weakness of it, partly because it refers to only two levels of explanation; the self and, to some extent, the context. Knowledge about risks is only one of the possible factors at the level of self and the fact that needle exchange exists indicates that a contextual social policy is in operation. It is argued that the potential role of a needle exchange in changing behaviour may be usefully considered at other levels of explanation as well as more in depth at specific levels of explanation.

Let us take the example of a fixed site needle exchange that forms the focus of this study. How might setting and situated activities be relevant? The service may function as a place for clients to interact and thus be a significant venue within drug using social networks. Consequences of this may be that drug dealing and possibly drug using will occur in or around the institution. The service is staffed by workers who interact with clients even if this is primarily centred around the core function of needle exchange. These interactions and their quality may be more or less encouraged by the way the service is structured, its operational policies and the training and attitudes of the staff. Their working approach may have an impact on how clients use the service and these may be usefully considered in terms of the motivational strategies outlined above. As noted in this chapter, the early needle exchanges were noted for the range of services offered in addition to needle exchange. These may encourage or discourage clients to maintain contact with the institution and impact on the social interactions that occur within the service. It is clear from these examples, that processes will occur within or around a needle exchange that are essentially social in nature.

It is therefore wrong to maintain a narrow vision of how needle exchanges operate based on simplistic and only partially useful theoretical models. It is necessary to consider the range of factors within the framework and to explore what is occurring in or around the needle exchange that may be significant in changing risk behaviour. To date this had not been considered in the literature. Taking this wider view of how needle exchanges may operate with a specific emphasis on motivation and social processes is important in developing these services to maximise their harm reduction potential.

In the following chapter the aims of this study and methodological issues are described.

Chapter 2 Methodology

2.1 Introduction to the methodology

The aim of this study is to explore how a needle exchange may impact on the injecting behaviour of its clientele. In the preceding chapter, theories are outlined which have been used to explain how needle exchange, as a health intervention, may impact on injecting behaviour. It is argued that, on the whole, these theories have limited explanatory potential and therefore a wider consideration of health and injecting behaviour as well as the more general processes involved in behaviour change is required. To draw these ideas together and to achieve a conceptual overview of the issue, a layered framework is proposed. In this chapter the research questions are outlined and the methodology of the study, including the use of the framework is described. The rationale for this methodology is given and the research methods used are explicated. The practical aspects of the study make up the final sections of this chapter.

2.2 The research questions

In contrast to many studies evaluating needle exchange services, this study looks beyond the core function of providing injecting equipment to consider the role of other aspects of the service, in particular, how the service provides a venue for social interaction, the ways clients use the service and how this may impact on their drug using and injecting behaviour. This study is therefore concerned with understanding social *process* and *interaction* within a particular *setting*. These areas of enquiry were formulated as a consequence of my involvement with the service which is described in Section A of this thesis. In the following section, I argue that the nature of these research questions and their basis in my interests and role as a clinical psychologist suggest the use of a qualitative research methodology.

2.2.1 Qualitative methodology and the research questions

Orford (1995) outlines three reasons why qualitative research may be attractive and relevant to practitioners. These refer to the viewpoint, focus and aims of the research. First, as indicated above, my position in relation to the research could be described as an "insider". That is I had an active clinical role in the service which was not distinct from my position as researcher. A qualitative methodology can be contrasted with a quantitative methodology which derives from a positivist epistemology and a concern with objective hypotheses testing and replication with little focus on the role of the researcher (Banister et al., 1994). In contrast, a qualitative methodology leads to interpretive studies of issues in which the researcher is central (Banister et al., 1994). This benefits the research process since it grounds the formulation and understanding of the questions and data within the context and area of enquiry.

Secondly, the concern of this study is with complex events in a specific context. Henwood and Pidgeon (1995) suggest that a qualitative paradigm is suited to this kind of search for meaning and understanding. Instead of objectively observing and measuring behaviour, I am concerned with understanding the meaning of social processes in a specific setting. The nature of the questions therefore suggest the use of qualitative research methods, which Henwood and Pidgeon (1995) describe as a "technical" justification for the approach.

Thirdly, this study aims to develop theory inductively from the data. As indicated in Chapter one, existing theoretical understandings of how needle exchange may impact on drug using behaviour is limited. In this study, grounded theory is used as an appropriate set of methods to formulate ideas and develop theory (Rennie et al., 1988; Henwood and Pidgeon, 1992).

In the following section the philosophical underpinnings of qualitative research are highlighted and some key issues about the validity of this approach and the implications for the practical implementation of grounded theory are raised.

2.2.2 A philosophical basis to qualitative methodology

Qualitative methodology is based on two philosophical positions: realism and social constructionism (Bannister et al., 1994). Briefly exploring these positions raises some issues that are important to consider in relation to the methods used in this study. A realist approach suggests that it is necessary to consider humans as having power to be reflexive and give accounts of their behaviour (Bannister et al., 1994). It leads to methods that will actively engage with this process through intensive studies of individual cases. This leads to the generation of theory from the data, similar to grounded theory as developed by Glaser and Strauss (1967).

A social constructivist approach takes a different position. It suggests that knowledge produced in research both creates and describes the world and that meaning is socially constructed within the research (Bannister et al., 1994). A contradiction is apparent from these two positions in that, on the one hand, theory is assumed to emerge from the data but on the other hand, interpretation is constructed and influenced by the researcher's subjectivity. Henwood and Pidgeon (1995) label this as an issue of "induction and the problem of grounding" (pg. 117). Resolving this issue is important since it has implications for the validity of qualitative research. Henwood and Pidgeon (1995) suggest that feminist work on theory and method is useful in addressing this concern. Essentially a feminist position indicates that experience is always mediated and researchers must therefore be conscious of their subjectivity. By explicitly placing the researchers position within the interpretative process their role becomes more transparent and gives the research more validity.

Charmaz (1995) integrates these constructionist ideas with grounded theory. In this the researcher defines his or her position in relation to the process of data analysis but is at the same time open to new interpretations and ideas. Henwood and Pidgeon (1992) characterise this "constant interplay between data and conceptualisation [*as*] a flip-flop between ideas and research experience" (pg.104). They suggest that this does not provide a simplistic answer to ascertaining the validity of qualitative research (Henwood and Pigeon 1995). Instead, they write that the extent to which further questions are facilitated (generativity) and the rhetorical power of the

arguments presented should be considered as a marker of the usefulness of a piece of research. They also refer to the concept of "strong objectivity". This involves the researcher being explicit about the interpretative processes involved in the research. One way I address this issue in relation to my research is by reflecting on the framework I have adapted as outlined in the previous chapter.

2.2.3 The research framework

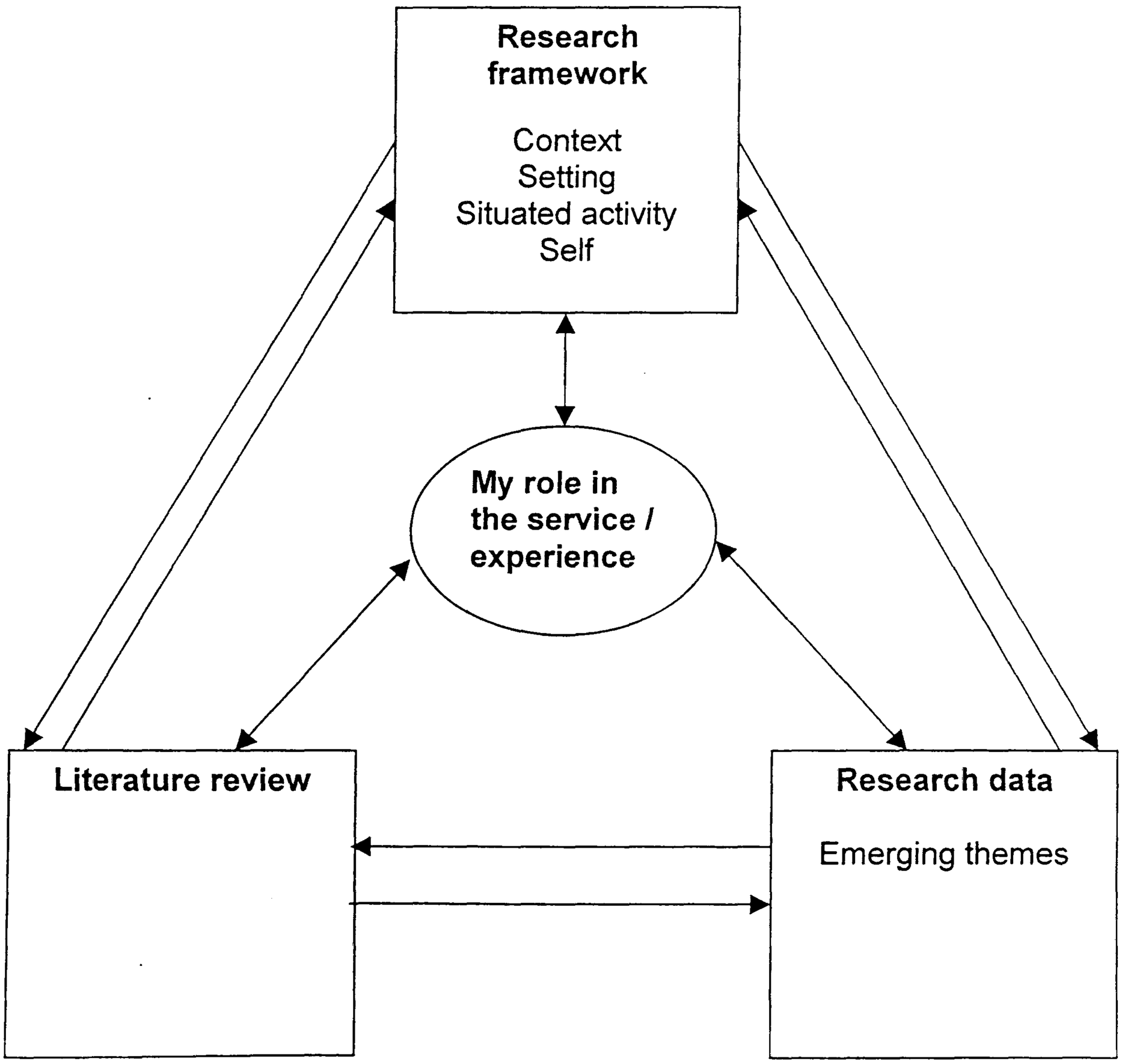
The research framework I have used is based on ideas formulated by Layder (1993) in which he proposes a research map consisting of a number of levels. My attraction to his ideas is that they provide depth to thinking about the processes and influences on injecting risk behaviour and enable individual behaviour to be placed within a psychosocial context. Layder uses these levels to refer to multiple scales of social reality. There are no clear boundaries between the levels: they overlap and interweave. The usefulness of this map is that, rather than constraining the researcher on one side of dualistic debates researching social reality, such as micro (individual) versus macro (social), it allows the simultaneous use of broader theoretical positions as well as more detailed analyses. At the same time Layder argues that by avoiding established dichotomies, which either prioritise theory testing approaches, such as experimental psychology, or theory constructing approaches such as grounded theory, the most effective use of theory can be achieved. Rather than these approaches being seen in opposition they can be seen as serving specific research needs in relation to different aspects of the research question. If both approaches are used together, research can both build and test theory. Layder's model fuses theoretical and methodological perspectives which have tended to be seen in opposition. Thus a layered model gives theoretical depth in emphasising the interconnectedness of levels of social reality and methodological rigour by accepting the dynamism of the research process.

In relation to this study, the focus of the research is at the level of self and situated activity, particularly the relationship between the two. However, the extent to which the setting and context impact on these levels is also considered within the practical constraints of the enquiry. The methodology used is both theory *testing,* as it explores the significance of social processes on

drug using behaviour and also theory *generating*, as the mechanisms by which these processes operate in the context of a needle exchange have not been sufficiently explained in the literature.

Drawing these ideas together, I have formulated a diagram (Figure 2.1) to describe research as a circular reflexive process. This diagram illustrates how my position within the service was central to the study. It was from my experience that I developed my initial research ideas. However, these ideas were also refined through an interaction with the literature, data and the use of Layder's framework as a heuristic to integrate some of these ideas and emerging themes. These three aspects can also be seen as mutually reinforcing; themes that emerged through the process of data analysis were explored in the research literature while utilising the framework as a way to help organise my thinking. Part of the difficulty in adopting this approach is that the writing up of research requires turning this circular process into a linear story. This diagram is also relevant to the process of data analysis described in Section 2.4.

Figure 2.1 Diagram to illustrate research as a circular reflexive process



2.3 Method of data collection

The research questions were formulated and explored through semi-structured interviews with the clients and staff. The rationale for interviewing clients and staff was to gain different perspectives. This can be understood in terms of triangulation, a key validity issue in qualitative research (Stiles 1993). The method of semi-structured interviewing fits well with qualitative analysis and grounded theory (Smith, 1995; Charmaz, 1995). It is used as a means to gain a detailed account of a participant's beliefs or view of a particular topic and gives more flexibility to the interviewer than structured interviews (Smith, 1995). The theoretical position adopted in relation to the interview is that outlined above: that participants can give an account of events which represent their beliefs. This relates to a phenomenological perspective (Smith, 1995), but also to a position that sees meanings as negotiated within the social context of the interview process. This draws more upon a symbolic interactionist position. Smith (1995) calls this an "interpretative phenomenological approach" and is similar to Charmaz's (1995) constructionist version of grounded theory. In applying these ideas, there is an attempt to enter the psychological world of the participants, to give them the opportunity to tell their story. The schedule therefore acts as a rough guide, rather than an explicit set of directions.

2.3.1 Constructing the interview schedule

Smith (1995) indicates that producing the interview schedule is an important stage in thinking explicitly about the research process. Since I interviewed both staff and clients, two schedules were devised, although the questions were based around similar themes. The first stage involved in constructing the interview schedule was a broad consideration of themes I wanted to explore. For the clients, my interest was in the ways they used the service. I was concerned with both their description of how they used the service as well as their perceived reasons for using the service. Stiles (1993) suggests that more subtle and potentially useful data emerges in response to what rather than why questions. I therefore focused on questions that would elicit description. Secondly, I was interested in the social interactions that occurred in the context of using the service, both with other clients and the staff. I also wanted a sense of the participants' perceived

quality and value in these interactions, to build up a sense of the meaning and function of these relationships. Thirdly, to contextualise these interactions, I was interested in the clients' use of other services and the nature of their relationships with other professionals, friendship networks and forms of social support such as family and partners. Fourthly, I wanted to explore possible connections between these social interactions and drug using behaviour.

In relation to the staff I explored similar issues, in particular views of their work and interactions with clients. My starting premise was that, since these interactions made up their day to day work, they would have a useful perspective on these issues. The relevance of these broad themes identified in this initial stage of constructing the schedule was discussed in research supervision and expert consultation was sought from a researcher familiar with qualitative methods applied to researching drug using behaviour and the social networks of drug users. This led to a revision of the schedule and inclusion of specific supplementary questions.

The second stage involved in constructing the schedule was putting these broad themes into an appropriate sequence. This involved considering the most sensitive areas and placing these later in the schedule to minimise participant anxiety (Smith 1995). The third stage involved refining each theme to specific areas and thinking of appropriate prompts. It should be noted that, in using a grounded theory approach, it is difficult to separate the data collection and analysis (Charmaz 1995). Charmaz suggests that it is important to think of the initial ideas as "points of departure" (pg. 32), as a means to develop rather than restrict ideas that emerge from the data. Consequently, as the data collection process proceeded, the schedule was further refined to explore ideas identified from the interviews. The initial interview schedules can be read in Appendix A.

2.4 The process of data analysis

Interviews were taped and transcribed verbatim into eight texts. The process of analysis was based on that described by Ritchie and Spencer (1994), Smith (1995) and Charmaz (1995). These authors describe systematic approaches to analysing qualitative data. A systematic approach to

the analysis is important in demonstrating the reliability and validity of interpretations made (Stiles, 1993). My concern was to draw out themes grounded in the data and to reflect on the meaning and relevance of these in relation to the ideas presented in Chapter one. Stiles (1993) suggests there is not a clear boundary between observation and interpretation in qualitative research and therefore the analysis is not separated from discussion and are presented together in Chapters three to eight. Smith (1995) writes that this is an appropriate way to present qualitative data and analysis. In addition to the authors indicated above, I also utilised Layder's (1993) ideas concerning the interconnections between themes and layers of social reality. The various stages in this process are described below.

1. Familiarisation. This is self explanatory and involved an immersion in the data. Tapes were listened to, transcribed and then read a number of times. Notes were made of points of significance and summaries of participants' responses. This process began after the first interview and was important in determining when to stop the process of data collection. This is a further aspect to the research process employed, that data collection continues until what Rennie et al. (1988) calls a point of "saturation" is achieved. That is when the participants' descriptions of the issues under study have been thoroughly explored.

2. Identifying a thematic framework. This was based on the ideas noted in the first stage, and could be described as "coding" the data (Charmaz 1995). This thematic framework evolved through the iterative process of reading the transcripts, refining and revising the framework as required. This starts the process of moving the analysis from being more descriptive to becoming more analytic. This was a spiral-like process of altering the framework based on the re-reading of texts and further interviews.

3. Labelling. The third stage involved labelling the data into manageable pieces by applying the thematic framework to the data in its complete textual form. Contradictions and connections were sought in this process, again altering the framework as necessary. This repeated re-reading of the transcripts and revision of theoretical ideas grounded in the data was part of the inductive process of achieving a valid representation of participants' accounts (Stiles, 1993). Numeric

references based on key themes were recorded on each transcript.

4. Charting. The labelled data was taken from the original text and grouped by the themes identified at stage two. This was assisted by the use of a standard word processing package, the data set being sufficiently small not to require the use of a qualitative research data processing package. As the data set was limited the "chart" consisted of a list of quotes with an identifying code for each participant, page and line from the original transcript. A description of the key themes identified at this stage can be read in Appendix B.

5. Mapping and interpretation. This stage involved interpretation of the data set and forming conclusions. Charmaz (1995) describes this stage as memo-writing, the step between coding and analysis. This involves looking for underlying assumptions and how the categories change and develop. This leads to developing theoretical ideas from the data.

6. Reflection. The final stage involved a return to the initial research questions and the literature review, addressing these in terms of the data and the extent to which they add to existing theories. I also used Layder's framework at this point to explore interconnections between levels of explanations so as not to constrain the analysis and discussion to a specifically psychological discourse. This final stage in the process is outlined in Chapters three to eight. The ideas developed in these chapters were also presented to a number of people from different theoretical standpoints and discussed in research supervision. This was part of reflecting on the validity of the interpretations made in the study (Stiles, 1993).

In the following sections background issues such as the location of the study, the selection and description of the participants are outlined.

2.5 The setting of the study

This study was conducted in a needle exchange based in central London. It was one of the first needle exchange schemes set up in the UK. At the time of the study, November 1996 to March 1997, the opening hours were 10am to 5pm, Monday to Friday. Free injecting equipment was available to clients including syringes and needles of various sizes, swabs and sterile water. Returns of injecting equipment were actively encouraged and incineration bins were also distributed for storing used injecting equipment between visits. It was acceptable for clients to state that they returned equipment to other services and still be provided with new injecting equipment. Other services on offer were the use of a telephone and primary health care from a nurse who assessed and provided some medical care such as dressing and cleaning abscess sites.

The service was staffed by nurses with either general or psychiatric training, plus people employed as drug workers with a non-medical background. Three staff were required to open the project for exchange and four to run a "drop-in", where clients could stay and provided with tea and coffee. Staff were trained to provide harm minimisation advice and developed specific pieces of casework with clients as required.

The project had developed to offer very low threshold service provision. Clients did not need to give their real names and no limitations were placed on access by area of residence. Certain ground rules, formulated on the basis of maintaining safety for clients and staff, were in constant operation and transgression of any of these rules by particular clients resulted in a review of their continued access to the service. Unacceptable behaviours included violence, actual or threatened, drug dealing and abusive language.

A typical day at the service would be a morning session, offering exchange of injecting equipment only, followed by an afternoon of exchange and drop-in. The atmosphere was informal and staff and clients would engage in a variety of interactions. Clients also used the drop-in to interact with each other and as a meeting place. These interactions were discreetly monitored by staff to ensure that there was no dealing of drugs on the premises. A description of the drugs used by clients of

the service and the basis to the local drug dealing market around the service is described in Chapter one (Edmunds et al.,1996)

2.6 Recruitment of participants

Ethical approval for this project was given by the research ethics committee of the local health authority and can be read in Appendix C. Once this had been given, I approached potential client participants within the service. Clients were initially approached randomly and engaged in a discussion about the project. They were given an information sheet (Appendix C) and any further questions they had about the project were answered. Three clients refused to be interviewed stating that they did not have the time. A further three clients expressed an interest, agreeing to return at a later date, but did not keep these appointments. This highlights how there were recruitment difficulties, perhaps to be expected with this client group, which was an issue in terms of the final sample size (Turpin et al. 1997).

The most successful strategy for recruiting participants was to be in a position to be able to interview them immediately after they had been approached. In the early stages of the recruitment and interview process, the participants were long-term regular users of the service and well known to the staff. They also fitted the typical demographic profile of the service by being white, male and in their early thirties. In the later stages of recruitment, a female participant was sought, as well as a younger client and one who was not well known to the staff. It should be noted that the final sample were all white, British.

Selecting participants in the later stages of recruitment on the basis of difference is acceptable in terms of the methodology used and the aims of the research which were about developing ideas rather than testing hypotheses. It can be justified as an attempt to avoid what Miles and Huberman (1994) call "holistic fallacy". That is interpreting events as being more holistic than they are. Seeking to recruit a client not well known to the staff was deemed important since interactions between the staff and clients were a particular focus of the interviews.

Staff participants were selected on the basis of my knowledge of their roles and responsibilities. I particularly wanted to interview the manager, someone from a nursing background and another from a non-nursing background to get as broad a range of perspectives as possible. The justification for selecting client participants equally applies to the staff.

2.7 The interview process

Having agreed to be interviewed, clients were asked to sign a consent form (Appendix C). Clients were interviewed in a room within the service or in a local cafe. Interviews were audio taped and lasted between 45 and 90 minutes. Clients were given a £5 shop voucher as a gesture of thanks for their time. My impression was that this voucher was appreciated by participants but was not their primary motivation for agreeing to take part. Five interviews were conducted with six clients over a period of four months. Staff participants were interviewed during their working hours in the service and not given a voucher. Three of the five staff were interviewed during the four-month period. In total nine participant's (staff and client) were interviewed for the study. Turpin et al., (1997) suggest that five participants should be a minimum in qualitative research as part of a clinical psychology doctoral thesis.

2.8 Description of participants

Throughout this thesis the actual names of clients and staff have been removed to ensure confidentiality. A brief description of the participants follows.

Clients 1 and 2 were male and related (the relationship is not specified to protect confidentiality), close in age and in their late twenties. They were interviewed together. They were well known, long-term users of the service and had used most of the facilities. They regularly presented to the service with a range of legal, accommodation and physical health problems. In the analyses chapters, the quotes are taken together and denoted 1/2 as it was difficult to distinguish their voices in the taped interview.

Client 3 was an older woman in her late thirties who had more recently made contact with the service. She was a street sex worker.

Client 4 was an older male in his forties who lived with his family in council housing accommodation in the same borough as the service. At the time of the interview he was actively seeking a period of respite in a local service offering residential, short- term crisis admission.

Client 5 was a younger man in his early twenties. He was new to the service and unknown to the staff. He had a history of heroin use and had recently come to London to work as a cook. However, his employer had become aware of his drug use and had suspended his employment which had led to a loss of accommodation. He lived in a shared house in South East London.

Client 6 was a man in his mid thirties who was using the service only intermittently. He lived outside London with his wife and, although he used a similar range of drugs as the other participants, had recently contained this in short episodes.

Staff 1 was the manager of the service. He was trained as a psychiatric and general nurse.

Staff 2 was recently trained as a social worker and employed on an ancillary and clerical grade. She was soon to leave the service to work in a structured day programme for drug users on probation.

Staff 3 was a recently trained psychiatric nurse. She had worked in the local NHS prescribing drug service prior to taking a job at the service.

In Chapters three to eight, quotes are attributed to these participants using the following notation: (c3) = client 3, (s2) = staff 2 etc.

2.9 Summary

A qualitative methodology approach is proposed for this study. This is because the research questions concern subjective accounts of social processes and interactions and the study attempts to interpret the meaning of these interactions in a specific setting. A further reason that a qualitative methodology was deemed appropriate for this study is that it attempts to identify emerging themes and ideas from data to generate potential theoretical ideas about how a service may be in a position to impact on drug using behaviour. The justification for this approach is based on a consideration of the philosophical underpinnings of qualitative methodology, particularly issues of validity. The process of data analysis is outlined as well as relevant background information to the study.

The following chapters outline the analysis and discussion of key theoretical ideas and are structured around the four levels described by Layder (1993). Although each element of the framework is considered in turn, connections between these levels are highlighted and brought together in Chapter nine, the conclusions. Appendix B may be usefully referred to in the reading of the following chapters and a research map is outlined below (figure 2.2) to illustrate the use of the framework and also to assist in reading the analysis.

Figure 2.2 Research map

Object	Determinants of risk behaviour / theories of behaviour change	Key findings	Role of service
Chapter 3 Context: General structures.	Social exclusion: -Criminalisation of drug use. -Socio-economic deprivation and risk behaviour. -Restricted treatment options. Social inclusion: -Harm reduction as a social policy.	- Creation of illegal drug markets. -Marginalisation from support structures. -Improved access to injecting equipment as a factor in safer drug use. -Service as an access point to other services. -Enables changes in social situations. -Distinct working practice.	-Reduces social exclusion. -Increases the availability of injecting equipment. -Provides a supportive contact point. -Approach facilitates engagement and contact.
Chapter 4 Setting: Organisational structure / Geographical location.	-Drug markets, drug use and access to injecting equipment. -Structure of the drug market. -Social context as an influence on quality of relationships among drug using networks.	-Market structure not conducive to positive peer interactions or emergence of clear peer leaders. -Proximity of service to the market facilitates access and ongoing contact. -Service as a transitional space, distinct from the market and serving different functions.	-Position of service facilitates initial and ongoing contact with drug users. -Low threshold access to injecting equipment close to the point of drug purchase. -Provides a safe bounded place for clients to interact. -Exists as a potential venue for peer interventions.
Chapters 5,6,7 Situated activity: Interaction.	-Social networks, peer norms and drug using behaviour. -Social support and health behaviour. -Motivation and processes of behaviour change. -Motivational interviewing and therapist behaviours.	-Negative view of other clients. -Safer drug use communications. -Use of network to sanction anti-social behaviour. -Minimal support networks. -Positive perceptions of relationships with staff. -Staffs' working approach facilitates these perceptions. -Support and esteem building functions to relationships.	-Venue for facilitating positive peer interactions. -Source of various aspects of social support. -Facilitates open communication about drug use. -Quality and functions of interactions potentially significant in facilitating safer drug use.
Chapter 8 Self: Individual.	-Functional models of drug use / behaviour. -Mood, self esteem and risk behaviour. -Health behaviour models.	-Self image. "Junkie" vs. "drug user". Self esteem. -Use of service for psychological support.	-Facilitates positive self image. Esteem building. -Psychological support.

Chapter 3 Analysis: Context

3.1 Introduction

The context refers to macro levels of social organisation within which the setting, situated activity and self operate (Layder 1993). Context could also be described as the distal influences on a person, including culture, class and ideology (Smail 1990). This level of analysis focuses on the consequences of social policies and laws (ideology) that are designed to control and or reduce the harm associated with drug use. This is manifest in client participants' reports of their drug using behaviour, the ways they use the service and the staffs' accounts of their working practice.

Needle exchange is an example of a public health initiative and a consequence of a harm reduction social policy, designed to reduce the spread of HIV among drug users and to the general population. It aims to improve injecting drug users' access to injecting equipment in order to reduce sharing and exists as a pragmatic response to the fact that people inject drugs despite policies aimed at stopping this. It could be argued that needle exchange facilitates and therefore normalises drug use. Harm reduction initiatives such as needle exchange thus stand in contrast to the more dominant policies, laws and discourses which make use and possession of some drugs illegal, and restrict access to other drugs within a narrow and medically defined range of treatments. The consequences of the coexistence of these various policy discourses for how a service based on harm reduction ideas operates and for how the clientele use the service are complex. I argue that some consideration of these issues is important in understanding how a service may impact on drug using risk behaviour since these policies may potentially constrain or enable the extent to which this occurs.

The impact of these contextual factors is considered in relation to four themes that emerge from the data. First, non-availability of injecting equipment as a factor in drug using risk behaviour and improved availability following contact with the service. Secondly, initial contact with the service as a consequence of buying drugs in the area. Thirdly, negative perceptions of treatment agencies and differences in working practice between the service and treatment agencies. Fourthly, the

service as a resource and source of support in addressing aspects of social exclusion.

3.2 Harm reduction and access to injecting equipment

Increasing the availability of injecting equipment is the primary purpose of needle exchange. Research has shown that non-availability is commonly cited as a "reason" for sharing and evaluations of needle exchange services note reductions in sharing among their clients (Donoghoe et al., 1992a). In this study, all the participants reported using the service to obtain sterile injecting equipment. This was contextualised in accounts of difficulties in accessing equipment prior to contact with the service and these can be seen as examples of how a policy initiative can impact on drug using behaviour.

3.2.1 Non-availability of injecting equipment and risky drug using behaviour

Difficulties in accessing injecting equipment were cited as a contributing factor in various risk behaviours. For example, one participant said he had experienced difficulties buying injecting equipment in pharmacies:

> "One of them only used to sell them in packs of 12 and other times they didn't have none in, so it was a bit of a lottery." (c1/2).

Consequently he had reused old equipment:

> ".... sometimes on a Sunday you didn't have a works.... you'd have to go through your bin to try and find the cleanest one ....." [1] (c1/2).

Another participant said that the cost of injecting equipment, prior to contact with the service, had led to reusing with consequent health problems.

> "I didn't have a lot of money so I would buy one packet of 10 which I had to make last a week and I was having 12-15 hits a day. So you can imagine how blunt they were by the end of the week.... It was no wonder I ended up with an abscess.... " (c3).

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[1] Explanation of notation. .... refers to an omission of text or when the quote is taken from within a larger passage of text.

As another explained,

> ".... a lot of the time you're desperate to make the money to score let alone anything else on top, so a lot of the time you made do with what you had. I'd use the needle twice .... And I've had to use them more than twice obviously on occasions." (c6).

These statements are indicative of how controls on availability of injecting equipment and financial considerations, may constrain "rational" health related behaviour. One participant said that non-availability, prior to contact with the service, had led him to share injecting equipment, despite knowledge about AIDS.

> "..... see, even with AIDS and that, because you haven't got a place like this and you can't go and get works and you've got an old works, you've got someone else's works, you're inclined to use that". (c4).

This quote illustrates that despite knowledge about the risks of sharing, non-availability of injecting equipment constrained the extent to which this was acted upon. While there are likely to be multiple mediators of risk behaviour, policies that determine access to injecting equipment are a crucial factor to consider in the extent to which sharing might occur. Prior to contact with the service, various problems were cited in accessing injecting equipment and this was thought to contribute to risky drug using behaviours, including sharing injecting equipment.

3.2.2 Availability of injecting equipment and changes in drug using behaviour

Five out of the six participants indicated positive health benefits as a result of improved access to clean injecting equipment through contact with the service. For example, one man said,

> "..... I've got a complete supply of new needles, I don't have to reuse - I don't have to sharpen my needle on a matchbox any more." (c4).

He also cleaned his injection sites with sterile swabs from the service and thought that, together with using new injecting equipment, this had reduced his injecting related problems.

> "I never used to use swabs before I put it in. Now when I do, I clean it first, have me injection, I take it out and I clean it again. I don't get half as much infections now as I used to in the old days. Since I've been coming here the last three years I haven't had none of that because I've got clean works all the time." (c4).

But perhaps most significantly he claimed to have stopped sharing since using the service.

> "Since coming here I haven't used anyone else's. I just come in every week and I get my works for the complete week." (c4).

These quotes illustrate that the service was fulfilling its primary purpose of improving drug users' access to injecting equipment. In the case of this man it was facilitating a personal strategy of getting a weeks worth of supplies at a time, as well as reducing injecting related health problems. As with the occurrence of risky drug using behaviour, changes in these behaviours are also likely to be a consequence of multiple factors; however, improved availability as a harm reduction policy initiative is an essential enabling factor.

These points are indicative of how a social policy can impact on individual behaviour. For the injecting drug user this can be conceptualised in terms of motivation; difficulties obtaining injecting equipment, including the costs involved, become competing contingencies to individual or peer norms about safer injecting. Improving availability reduces the salience of these competing contingencies which facilitates the probability that safer drug use can occur. In Chapters four to eight, other mediators of safer drug using behaviour, from different levels of explanation, are discussed. A final point to consider in relation to the impact of harm reduction policies is the participants' perceptions of their access to injecting equipment.

3.2.3 Limitations of harm reduction initiatives

Despite using the service and noting improved access to injecting equipment, some of the participants thought that this access was still poor, particularly when the service was closed. All the participants used or had used pharmacies as a source of injecting equipment. However, one stated that pharmacies local to the service had changed their opening hours and had stopped offering the service due to injecting equipment not being returned. She indicates that services are valued when they fit with her drug using and buying patterns. The chemist was convenient because it offered a service in the evenings and at weekends.

> "**** in **** Street used to do it. And that was great because they're open till 7 o'clock and they're open Sundays. But they stopped doing it after about 6 weeks

> because people weren't taking them back. That is a real nuisance actually because **** was so convenient for me. Because I'm always up here on a Sunday scoring." (c3).[2]

She also felt that the remaining pharmacies that operated exchanges were too far away from the dealing areas and were consequently inconvenient for her. The importance of low threshold access to injecting equipment close to areas where drugs are bought appeared to be important. As one man said, people who are withdrawing would not adapt their drug use to the opening hours of services and consequently may be at risk of reusing or sharing injecting equipment.

> "..... getting access to needles is so important for a drug addict if he wants to keep clean, if he wants to not get hepatitis, AIDS whatever. Over **** across the road, at 3 o'clock or 4 o'clock you can get needles. They won't serve you before then or after that. You get a junkie who needs his gear at 10 o'clock in the morning or 11 o'clock in the morning, he ain't going to wait 4 or 5 hours for them to be able to serve you a needle, he's going to use someone else's needle, or he's going to use an old needle which is going to cause infections." (c4).

This quote illustrates that being in withdrawal from drugs is a competing contingency to beliefs about using drugs safely and indicates how availability may mediate the salience of these beliefs. It indicates how any model of injecting behaviour needs to account for environmental factors that may constrain or enable the occurrence of that behaviour. The perceived inadequacy of pharmacy provision in the area around the service is an indication of the limitations of harm reduction initiatives in the locale. In the context of other policies which aim to control and curb drug use, it is perhaps not surprising that access to injecting equipment may not be as comprehensive as some drug users may require.

Having considered a potential relationship between social policies that determine the availability of injecting equipment and injecting risk behaviour, the next section looks at the impact of the criminalisation of drug use on the ways clients use the service.

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2 Explanation of notation. **** refers to names of individuals, places or services that have been removed to ensure confidentiality.

3.3 Criminalisation of drug use

The impact of criminalised activities associated with drug use can be described in terms of social exclusion. The consequences of this are manifest across each of the layers of analysis, in terms of how participants used the service, how the interactions within it were affected and in relation to client participants' self-image. One of the consequences of the criminalisation of drug use is the creation of illegal drug markets. Such a market is well established in the area around the service studied. (The relationship between the service and the market is considered in more detail in Chapter four). In this section, the participants' accounts of their initial contact with the service as a consequence of using the market is considered.

3.3.1 The drug market and initial contact with the service

Participants were asked how they first came to use the service. Five of the six participants accessed the service as a consequence of buying drugs in the local area. The remaining participant sought the service for a health related concern. The area around the service was well known as a place to buy drugs. For example, one man was told:

> ".... 'if you want to score during the day you have to go down to **** Street, to The ****,' and that was basically my first encounter down here." (c6).

Another said:

> "Come down to get some amps [*ampoules*] once, was told to come here, not to this address but to this road. And I see it." (c4).

These quotes indicate how the service has a close relationship to the drug dealing scene in the local area, by being initially utilised as a consequence of its geographical proximity to a drug dealing market. Information about this drug market came from other drug users, and is indicative of a drug users' network.

> "Basically a few friends come up here on the off-chance because they'd heard about it and they let us know. It was out of interest to try amps." (c1/2).

It could be argued that the service depends upon the local drug market for its clientele. However, it also exists as a low threshold access point to injecting equipment close to where drugs are bought.

The relationship between the market and the service is close to the extent that it is difficult to differentiate the participants' use of the service and their purchasing of drugs. Staff acknowledged that clients bought drugs in the area, but did not state that this was why clients used the service. This suggests a tension between the service and a market based on an illegal activity. This is explored further in Chapter four, but it is worth noting the apparent contradiction inherent in a service which benefits from the criminalisation of drug use in attracting clients, but also aims to minimise or reduce the harm associated with these policies. It is argued in this research that acknowledging this relationship enables a better understanding of how clients use the service and increases the possibilities of harm reduction work in the local area.

A third factor to consider in terms of the ways the service operates and is used by clients are policies that define the nature of drug treatment.

3.4 Drug treatment policy

A notable feature of the drug dealing scene around the service is the availability of methadone in an injectable ampoule form (amps). All the participants used the local drug dealing scene to purchase this form of methadone. Injectable methadone is not freely available from local treatment agencies due to government policies enacted at a local level which advocate the use of oral methadone. The restricted access to injectable methadone in the NHS and the market demand for it has been exploited by private doctors. This creates the conditions for an illegal drug market to develop. However, some participants had past experience of NHS drug treatment agencies. Their views of the way that treatment is defined and implemented offers some explanation as to why none of them were in contact with these services at the time of the research.

3.4.1 Experience of treatment agencies

Two participants expressed ambivalence or antipathy towards services and staff in NHS treatment agencies. In addition to being unable to obtain injectable drugs, they cited the treatment agenda, behavioural restrictions and the attitude of the staff in these agencies as reasons to avoid them. For example, one woman perceived the staff in one clinic as having a negative attitude towards drug users, feeling they were too ready to disbelieve them.

> ".... some of the other drugs services they treat you as if what you're saying is exaggerated. And OK, there's some people do exaggerate, but they have to learn to differentiate between the people who exaggerate and the people who don't. They can't automatically assume that everyone exaggerates." (c3).

She felt forced to engage in negotiation around her methadone prescription and, as a result of the staffs' negative attitude to drug users and what she perceived as unnecessary behavioural restrictions, stopped using the service.

> "I went to the **** a couple of times, I didn't like the place basically. Didn't like the atmosphere, didn't like the staff there, didn't like the way they treat you. Plus the fact you can't smoke in there...." (c3).

In relation to treatment agencies, the staff in the needle exchange were aware of how differently their service operated. One aspect was the absence of prescribing and the few restrictions they operated in terms of clients accessing the service.

> "Because you haven't got an awful lot to withhold from people, it's not like they're trying to get some methadone, Valium or anything. There's nothing that we really have to check out. You need it today, you can have it today." (s3).

In relation to the impact on relationships with clients, she suggested that the prescribing element of treatment agencies introduced a power imbalance which interfered with honest communication. In contrast,

> "they [*clients*] come here and they'll be more open to talk about what they are actually using and what's going on for them, because we've got no power and no script."(s3).[3]

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[3] Explanation of notation. Bracketed [] words in italics are additions to the quote to clarify meaning.

The limited prescribing options and the way in which some participants' perceived treatment to be delivered could be seen as excluding them from treatment agencies. They used the market around the needle exchange as a source of drugs and utilised the service as a consequence of contact with this market. A central focus of this study is the perceived quality of the interactions between clients and staff in the needle exchange. Because the service studied is not involved in prescribing, it is argued that a different quality to the interactions that occur within it are facilitated. However, even though the service was not defined as a treatment setting by either clients or staff, it was utilised by clients at times when they were drug free. This is explored in later chapters but suggests that the way treatment is defined by agencies, based on policies with a medical view of drug use, is one that is not required or that is actively rejected by some drug users. This is a further factor which may bring and help to maintain clients in contact with the service studied.

The criminalisation of drug use and the way in which treatment is defined can be described as having the consequence of social exclusion. Indicators of social exclusion such as homelessness have been associated with sharing (Donoghoe et al., 1992b). Conversely, harm reduction as a social policy can be described as being socially inclusive. This aspect of harm reduction, manifest in the various ways participants report using the service, is considered in the final section of this chapter.

3.5 Harm reduction and social inclusion

It is argued that the criminalisation of drug use and the way treatment based on substitute prescribing is defined and organised excludes drug users in a number of ways but also because of their exclusion they come into contact with the needle exchange service. Once they come into contact with the service some socially inclusive outcomes result. A theme that emerged from the data was use of the service for help in accessing housing and information about other support agencies.

3.5.1 Use of the service for practical support and access to other agencies

> "Well this is somewhere I've found has helped me a lot over the years. They've let me come in here at times when things were really bad for me. They let me come in here to sort out hostel accommodation and stuff like that. It hasn't just been coming here for needles. There has been the medical advice as well." (c3).

This quote is notable for how the practical support had been helpful when "things were really bad" suggesting it might have been psychologically containing. It was used by another participant as a source of information about other services,

> "Through this place I've got loads of other contacts. Like there is places where they do acupuncture and stuff like massages .... There's a place up **** - [*The*] ****. I got to know all them different contacts through this place." (c4).

As well as information, two other participants felt that a staff member had advocated on their behalf to get housed, using her professional knowledge and language to open doors which they had been unable to do themselves.

> "We was living on the streets at one time and she helped us, she got us a hostel, she got us into bed and breakfast. She phoned up **** [*Council*] and said "Look I've got 2 lads here in emergency situations and you're supposed to be helping them out but you're doing nothing." And they said come down the next day. She put it across beautifully, like a probation officer or something." (c1/2).

The use of service as a source of information about other services or as a way to access a bed for the night is different from the primary harm reduction function of providing injecting equipment. However, considering the social deprivation factors associated with sharing (Stimson, 1992a; Donoghoe et al., 1992b), this intervention may have been significant in facilitating a context more conducive to using drugs safely. The following quote indicates the value of this aspect of the service, as an opportunity for people to move out of the drug using world even though, it is very much part of that world;

> "It's like a never-ending circle [*using drugs*]. Just goes round and round and round. And this place is like an exit from there, you can get out [*of*] the circle." (c4).

The service was used by participants in a number of ways that may be construed as one step removed from the primary harm reduction function of providing injecting equipment. This is consistent with the early evaluations of needle exchange services which reported that these services were a low threshold way into other services. Although it is difficult to evaluate the impact of this aspect of service utilisation, it appears that the service is significant in reducing social difficulties, such as homelessness, that may be contributing factors in unsafe drug using behaviour. I suggest that these aspects of the service, can also be broadly conceptualised in terms of harm reduction as they serve the function of enabling people to improve the quality of their lives. This can be seen in terms of reducing the marginalisation and social exclusion of drug users.

3.5.2 Summary: Harm reduction and social inclusion

The research framework in this study outlines the importance of placing individuals and their behaviour in context. It is about understanding the context of clients' lives and the "actuality of [*their*] material power" (Hagan and Smail 1997, pg. 272). In relation to injecting risk behaviour, addressing social exclusion *is* harm reduction and part of enabling people to use drugs more safely. The following chapters narrow the focus of enquiry to consider possible social and psychological processes which also enable this to occur.

3.6 Conclusions: The context

In this section, context is defined in terms of the social policies and discourses which impact on service development and the people who use them. Some criminalise and marginalise drug users while others operate to counter these negative consequences. The impact of these contextual factors is most clearly demonstrated in terms of participants' stories of access to injecting equipment, initial contact with the service studied as a consequence of using a local drug market and the ambivalence expressed towards drug treatment agencies. As well as improving access to injecting equipment, the service was used to gain access to other services. This can be seen as reducing social exclusion and, it is argued, is an important harm reduction function of the service. Reducing exclusion can be considered in terms of motivation as it alters various structural

conditions to facilitate the behavioural probability that safer drug use will occur. Having somewhere to live becomes a place to store injecting equipment which potentially assists strategies of maintaining a personal supply.

The consequences of social exclusion and the role of the service in reducing this exclusion is a theme that emerges across the other levels of the research framework, setting, situated activity and self. The service and its working philosophy exists in opposition to discourses and practices that exclude drug users by reducing the harm associated with social exclusion. The next chapter considers the use of the service in terms of the setting. This develops issues raised in this chapter concerning the relationship between the service and the drug market and the service as a route out of a drug using world while at same time being part of it.

Chapter 4 Analysis: Setting

4.1 Introduction

The setting refers to organisational structures, the service, and the geographical location within which the situated activity, that is the interactions between people, occur. As indicated in the previous chapter, the service studied has a relationship with an illegal drug market. The market and the service can be thought of as two distinct settings. The differences are outlined in this chapter although from the client participants' perspective, a distinction between these two settings is unclear. This finding is considered in some detail; it is argued that the service, by being part of and yet distinct from the market, facilitates the work of the staff and the engagement of clients. This chapter is structured around three broad themes that emerge from the data. First, the market as a separate entity from the service and how its structure may influence the quality of the interactions between the people that use it. Secondly, the service as part of the market, which develops some of the themes outlined in the previous chapter. Thirdly, the service as a distinct setting from the market, the significance of this and how this is achieved through the interventions of the staff. It is argued that, because the service is part of but also separate from the market it exists as a transitional space, within which interactions that may be significant in changing or maintaining safer injecting behaviour are facilitated. The term transitional is used to describe a space rather than a (symbolic) object in a psychodynamic sense. This transitional space is characterised by particular qualities and social rules, through which people can move between identities of drug user and non-drug user.

4.2 The local drug market

As indicated in the previous chapter, purchasing drugs in the street dealing scene around the service draws drug users to the area. These dealing interactions, alongside evidence that the participants found out about the existence of the market from other drug users, indicates the existence of a network of drug users. Understanding the characteristics of this market is important to consider in relation to the quality of the interactions within the network and among the clients of the service. This has implications for the development of peer norms around safer

drug use and how interventions targeted at this social level may be developed.

4.2.1 The quality of interactions within the drug market

All the participants interviewed bought methadone ampoules in the area. All indicated that this was potentially problematic. In particular, concerns were expressed about being "ripped off", that is not receiving drugs paid for, receiving fake drugs, or having money stolen, all of which could occur with actual violence or the threat of it. Since buying drugs is an illegal activity, these exchanges are not regulated by the usual social structures which can be called upon to ensure a fair exchange of goods and money. This creates an inherent risk during these transactions. The concern of being "ripped off" featured more frequently than a concern about being arrested, the other major risk involved in buying drugs. An example of being robbed was given by one participant.

> ".... it seems to always be different people I score off, but the majority is people I know. There was one time, there was a group of us and there wasn't many amps about, and I gave my money to one person and someone ran off with my amp ...." (c5).

He went on to say that another person had assisted in retrieving the amp, illustrating that alliances are formed among people to sanction this behaviour. This indicates how the network can act to regulate the antisocial behaviours that occur within it (see Chapter five). This quote also illustrates a distinctive feature of this particular drug market, that is the number of dealers operating in the area. There is not a complex distribution network since the dealers are usually selling their own prescriptions. This gives a flattened structure to the dealing in the market, rather than a pyramidal structure that would characterise markets based around people's homes (Power, 1995). The consequences of this market structure are likely to be many but one aspect may be that it shapes the participants' generally negative perception of other drug users in the area. It appeared that trusting relationships were not facilitated and that the threat of violence was an implicit feature of the market. One participant suggested that drug users were not to be trusted:

> "We've got associates, no friends. That's all they are. I've got no-one I would class as a friend up there. I wouldn't trust them as far as I could throw them. You've heard the cliche about the user." (c1/2).

These two participants did not seek interaction with drug users beyond that involved in buying drugs. Another also expressed a caution in his interactions with people due to the potential threat of violence.

> "You've got to be careful who you speak to on the street and how you speak to people because you could say the wrong thing and before you knew it you've got a bloody knife in your back." (c6).

It is argued that the negative perceptions of other drug users in the network is a consequence of relationships within it being based around buying drugs and the particular structure of the market that militates against relationships based on trust developing. These findings about the market add qualitative information to the study by Edmunds et al. (1996), particularly how the structure of the market as an open system, leaves people within it vulnerable to exploitation and violence.

4.2.2 Summary: The drug market and quality of social interactions

This information about the market and the quality of the interactions within the network is valuable when considering the potential impact of peer based interventions. Overcoming some of the negative perceptions of others may be difficult and may constrain more positive exchange of information related to safer drug use. (This issue is considered further in Chapter five). In the following section the relationship of the service to the market is explored.

4.3 The service as part of the drug market

As indicated in Chapter three, the position of the service in relation to a drug market facilitates clients' initial contact with the service. In addition to this, ongoing contact was facilitated not only by the geographical position of the service, but also because of its identification with the market.

4.3.1 Ongoing contact and low threshold access to injecting equipment

The participants did not make a clear distinction between the market and the service. For example one said:

> "basically I come here to score and get me needles." (c6).

Another suggested that to facilitate buying drugs:

> "A little base is quite important really. Because it's somewhere to congregate. You know, people come here to get their works and chat and whatever. It's a sort of a centre." (c5).

Similarly, another stated the value in having the service as a geographical focal point to drug dealing,

> "It's much easier for those of us who've got to score on the street knowing we can go to one spot and if we wait for a half hour someone's going to turn up." (c3).

This was acknowledged by one of the staff but, in the context of referring to changes in the clientele from an older to a younger group of people, suggested that the service for younger people was,

> ".... more of a meeting place to buy and sell [*drugs*]." (s1).

It is argued that this lack of distinction between the market and the service is positive since it facilitates the function of providing clean injecting equipment to drug users. The service is ideally placed for clients buying drugs to access injecting equipment, particularly for those who use at the point of purchase. This may be particularly important since a study by Ross et al. (1994) suggests that availability is effective only if it extends to the time and place of injection. Stimson (1991) also indicates that sharing is correlated with using drugs at the point of purchase.

4.3.2 Summary: The service as part of the market and safer drug use

Sharing injecting equipment is more likely to occur in the context of a number of factors, for example, as indicated in chapter three, being in drug withdrawal and these will vary both between and within individuals. For some drug users at particular times a low threshold access point to injecting equipment close to the point of drug purchase may be important. This can be considered in terms of motivation. As Miller and Rollnick (1991) suggest, "removing barriers" that impede the occurrence of a behaviour is a motivational strategy to increase the likelihood of that

behaviour occurring. The proximity of the service to the market can be conceptualised in this way and may be important in enabling people to use drugs safely. In the following section the service is considered as a separate setting to the market.

4.4 The service as separate from the drug market

Although the market and the service can be considered as part of the same setting in terms of geographical location and perceptions of the clients interviewed, there was also a distinction between the two. This distinction was indicated by the staff and it is argued that this was part of facilitating a different quality of interactions between clients from those that occurred within the market.

4.4.1 Keeping the service separate - rules and boundaries

The staff were aware of the difficulties clients experienced in the market around dealing and consequently actively tried to exclude this activity from the service. Although staff attempted to create a safer, different space from the market, this had to be reconciled with encouraging access to the service. As indicated in Chapter three, there was a negative perception of treatment agencies by some client participants because of the perceived rules and working practice of these services. The issue of perceptions of power appeared to be important. This was also raised in relation to maintaining rules within the service. One staff member said:

> "We have our limits and our boundaries on clients' behaviour which is absolutely right, but we aren't perceived to have power over the clients." (s1).

He went on to state that there was a balance to be maintained between being non-coercive and accepting of a client's behaviour as a means to engage with them, but within certain boundaries to maintain some sense of safety.

> "If I try and force our philosophy about what the client should do, and the client's not prepared to go with that, I'm either going to lose them as a client or I'm not going to be able to work with them. You suffer negative interaction between us. That doesn't mean that within that we're going to let clients trample all over us either. We have to set limits and boundaries on what clients' behaviour is within

> that.... things that they are not allowed to do here.... a lot of that's around safety - not just safety for staff, safety for the client as well." (s1).

The difficulty in maintaining boundaries, while being mindful of clients' access to the service, was experienced as difficult by another staff member. She gave an example of clients trying to access the service when it was closed but,

> ".... as part of a professional team you've got to stick to boundaries. We've got rules, we've got opening hours. I think you've got to harden yourself to that whatever your personal thing is." (s3).

As might be expected when the distinction between the service and the market is blurred by clients, she often had to confront people about dealing. Usually this was met with a flat denial.

> "And then it makes you feel bad for saying something, even if you know what you've seen." (s3).

She said that invoking boundaries was particularly difficult with her clients because they may have had little positive experience of boundaries and that consequently it was often met with a hostile reaction.

> "I suppose it's knowing the desperation of some people and knowing that they've got very limited boundaries themselves. I suppose to enforce and maintain boundaries with people a lot of the time, if it's someone that you don't know very well, you do get aggression back." (s3).

The issue of boundaries was central to the working practice of the staff and I suggest that it is part of defining the service as distinct from the market. There was a delicate balance between creating a safe space for people to interact without creating a hostile, over regulated atmosphere. In Chapter seven, this is developed in terms of the staff's working approach, looking at the ways that boundaries are negotiated and how aspects of professional difference are invoked. In the next section the service as a setting for a different quality of interaction from the market is considered from the clients' perspective.

4.4.2 The drop-in and structure of the service

One element of the service was the drop-in time when clients were encouraged to stay and interact among themselves and with the staff. It is argued that the physical layout of the service

facilitated the staff's role in monitoring activity within the drop-in which in turn enabled a quality of interaction to occur between clients different from that in the market. The physical layout, although cramped, was small enough for staff to observe activities so that dealing could be excluded. The size also brought people who used the drop-in into close proximity with each other. This attention to the design of the service as a factor to facilitate interactions is described as important by Bilsen and Emst (1989) in relation to the practice of motivational milieu therapy.

From the participants' perspectives, the drop-in was valued as a place to wait for dealers and to exchange information about drug availability, but it was also valued as a safe place to interact. As one woman indicated,

> ".... people don't go to other people's houses. Because too many people have been ripped off when they've had people visiting their houses. The only places they go on is either in a drop-in or on the street. And on the street you're too busy looking out for the police, you can't relax and have a proper conversation, and anyway it's too bloody cold this time of year." (c3).

She said that part of the attraction of the drop-in was to be with other drug users, being with your "own kind" and this was different from her experience of a homeless persons' drop-in.

> "You know, you can sit in comfort and exchange knowledge. As I said, on the street you can't do it. Like the people who are living on the streets as well, it makes such a difference to have somewhere that they can relax with other drug users rather than somewhere like **** where they're surrounded by alcoholics, the mentally ill, completely straight people, rather than being among their own kind. At times like that you want to be among your own sort, when you can just sit and relax."

Her perceptions are not only evidence that the staff were successful in creating a different quality to the space within the service, but that this was a valued and unique place to be "among your own sort". The value and meaning of this is explored further in the following section.

4.4.3 The service as a transitional space

As indicated in Chapter three, the impact of policies of control in relation to drug use has the consequence of marginalising drug users and potentially excluding them from support structures.

In contrast, the service operates to include clients, to facilitate their integration. It is argued, from a more psychological perspective, that part of this integration is enabling people to be able to talk and express difficulties regarding their day to day lives and consequently to express ambivalence about their drug use. As one man said,

> ".... you can't go up to someone in a cafe and just go, fucking hell - I just bought a bit of gear, right fucking shit gear and I couldn't even bang it up, I had to smoke it. They'd look at you as if you're fucking off your head. But here I can come and say it." (c4).

He used a metaphor to describe the importance of being able to express these concerns.

> "Out there it almost seems that I'm a foreigner in another country, and when I come in here people speak English." (c4).

This conveys the sense of generally feeling alien and excluded while in contrast, within the service, feeling contained and understood. Being able to be with other drug users in a relatively safe environment and express difficulties associated with this life to people who were understanding appeared to be a unique and important supportive experience. This could be understood in relation to some of the functions of social support outlined by Orford (1992) but also importantly, in relation to drug use and behaviour change, it appeared to allow people to express ambivalence about their drug using lives. Expressions of ambivalence are associated with behaviour change and facilitating statements of ambivalence is one goal of motivational interviewing (Prochaska et al., 1992; Miller and Rollnick 1991).

4.4.5 Summary: The service as a transitional space

By being part of and yet distinct from the local market, the service represents a space between a drug using world and a different kind of existence. It is a space within which people can openly express concerns about their lives in a relatively safe environment. It is argued that it represents a unique space and one that could be described as transitional, a space between the market and its negative interactions and another world from which injecting drug users may feel excluded. It is also transitional because being able to talk about these experiences is part of being able to express ambivalence and, in addition to supportive interactions, may facilitate behaviour change. The

quality of these interactions is explored further in Chapter seven. In the final section of this chapter the possibility of using the position of the service and extending elements of the interactions that are facilitated within it to the market is considered.

4.5 Developing the role of the service within the market

The geographical position of the service suggests that it could be a venue within which peer intervention projects in the market could be initiated. However, this study indicates that the staff were reluctant to acknowledge the extent of the relationship between the service and the market. While this may be a consequence of the policies outlined in Chapter three, particularly the fact that the market is defined by an illegal activity, the timing of the study may also have some bearing on this finding. The service was under public scrutiny and the staff may have been under pressure to define the service as separate from the market. The problem with distancing the service from the market is that it potentially creates barriers that may impact negatively on how the service is used. It also suggests that the relationship is unidirectional, with the market impacting on the service, rather than one of mutual influence. This study indicates that the service enables the clients to interact in a safe environment, which is safe because the staff are active in excluding some of the negative behaviours that define the quality of relationships between drug users within the market. Secondly, there was some consensus among the clients interviewed about what constitutes antisocial behaviours, particularly those associated with dealing. Discussions about these issues could be facilitated within the drop-in and may be an initial step to defining a positive sense of community. Finally, and this is considered in the next chapter, secondary distribution of injecting equipment was reported by some participants. This is indicative of another way in which the service is in an ideal position to encourage interactions among a group of drug users that may be more conducive to safer drug using norms developing.

4.6 Conclusions: The setting

In terms of setting, key themes from this study indicate how the service is part of, yet distinct from, the local drug market. Being part of the market facilitates client engagement and continued

contact with the service. This proximity is important in terms of low-threshold access to injecting equipment. However, the service is also distinct from the market in that certain behaviours are excluded. The staff are active in maintaining this difference. However, there is a subtle balance to be negotiated between maintaining boundaries and difference from the market while at the same time creating a space in which drug users feel accepted and able to be open about their lives. This facilitates the service acting as a transitional space and may be significant in enabling people to change drug using behaviour. As a setting it is argued that the service is ideally placed to be a focus for peer norm changing interventions. The service exists as a focal point within the market within which positive interactions between clients were encouraged and could be developed. In the next chapter client interactions are considered.

Chapter 5 Analysis: Client interactions

5.1 Introduction

This is the first of three chapters exploring various situated activities, that is interactions between people and the relevance of these to the ways in which the service is used and participants' drug using behaviour. In this chapter the significance of themes that emerged from participants' accounts of their interactions with other clients are discussed. These are considered in terms of safer drug using peer norms and points to consider in relation to developing interventions at this level are raised. As discussed in the previous two chapters, the criminalisation of drug use and structure of the drug market can be seen as defining the quality of interactions amongst the clientele of the service studied. The following sections consider the nature of the relationships among the clients in more detail. Although the perception of others is largely negative, instances of support and harm reduction communications are also apparent and indicate potential ways in which peer interventions may be developed.

5.2 Negative perceptions of other drug users: Younger drug users

Participants were generally negative in their view of other service users and those using the local drug market. For example, two participants, despite being long-term and regular clients of the service, described themselves as outsiders and not ready to trust other clients.

> "Well we don't come from London see.... so we haven't really got contacts.
> "We've got a lot of people who say hello and talk to us, but even all them people I wouldn't trust."
> "There's no-one up there who I tell too much." (c1/2).

These participants indicated that there had been a change in the demographics of the network with an influx of younger drug users,

> "The old crew used to be better.... It's all new people now..... Now you're getting much more youngsters round here and they're the ones with the big mouths. They go around ripping people off." (c1/2).

Another participant also said it was the younger people who were intimidating and causing

difficulties in the network.

> "I think three years ago there wasn't so much young people involved so there wasn't so much aggro.... But since the youngsters have been coming on the scene lately, they tend to be causing a lot of trouble - physical stuff and aggressive talk and words, and shit like that. Whereas before we didn't have none of that really." (c4).

These perceptions may say more about the participants than a change in the network demographics, for example, as part of a process of distancing self from others. This is explored further in Chapter eight. It could also be argued that the network around the market is defined by its transience so that there will always be people of varying ages interacting within it. However, although this study is not able to ascertain whether there was a real change in the network, these quotes illustrate the ambivalence expressed towards others in the network by some of the longer-term service users. In contrast, the youngest participant, with the shortest length of contact with the service, was less negative about others, despite having recently been robbed. He said,

> "I do like coming up here to talk to people, other people I know.... there is quite a bit of a social aspect round here." (c5).

However, although he described some of the people he had met as "friends" the majority he would not trust.

> "There's a few people I would count as friends. There's quite a few honest people around here. Surprisingly. There's a handful of people I trust reasonably well - and a lot of people I don't." (c5).

The different view this participant had of the network may indicate that the negative perceptions of others is a result of length of contact with the network, as well as a possible age-related phenomena. The key emerging themes centre around trust and changes in the network.

5.2.1 Friends and support in the network

Although perceptions of others were generally negative, one man indicated an attachment to a select few people, who were either similar in attitude, had a sense of integrity or experience, or were different from the majority of other drug users. He mentioned two friends whom he had met

through the service. He had recently slept rough with them, despite having a home of his own.

> "..... There's two in fact.... who I'd count as friends. I spent last night with them. I mean I'm not homeless, but I spent last night on the street with them because they're my mates. And we got a draw [*cannabis*] and had a puff and that and we were all right last night, we had a good laugh." (c6).

He differentiated one of these friends from other clients that used the needle exchange.

> "***'s not a criminal, he's just a drug user. He's well educated." (c6).

This quote also illustrates an aspect of the construct "drug user", used as a means to differentiate people in the network (see Chapter eight). For his other friend he expressed some comradely concern.

> "If I see a friend who's down on his luck and I think he's going a bit too heavy, I'll pull him aside - like last night. I said, come on **** man. I've never seen you this bad. You've got to sort yourself out, you've got to get your head together." (c6).

This worry about the extent of a friend's drug use and the sense of camaraderie amongst this small group is indicative of a harm reduction and supportive interaction. This could be described in terms of companionship, one of the key functions of support outlined by Orford (1992). Moreover, attachments to a small number of others within a network of drug users is consistent with research by Rhodes (1996).

Indications of these types of relationships were, however, unusual amongst the clients interviewed. The majority of participants, particularly the older and longer service users, expressed a negative attitude towards most other clients. There was little sense that these relationships were supportive and in fact some participants appeared to want to distance themselves from the others. This appeared to be a consequence of the relationships being based around buying and selling drugs, an inherently risky activity. In the next section the ways in which these risks were managed are outlined as another aspect of interactions between clients.

5.3 Managing the risks of buying drugs: Use of the network to sanction antisocial behaviour

As drug dealing was the defining feature of the network, it was interesting to note strategies that participants used to reduce the risks involved. One man developed a behavioural style when buying drugs,

> "..... in all the time I've been coming down I've never been ripped off, no-one's ever tried to rob me or mug me. It's happened to countless people down there. Because basically I let people know that I don't take any shit, and if I'm going to buy something then you'll get my money as you give me the goods.... It's kind of how you put yourself forward really." (c6).

This highlights an individual strategy, presumably laden with the threat of retaliatory violence. However, the only female participant had developed an alternative strategy to manage the risk of being "ripped off" which did not necessitate presenting a "don't take any shit" image.

> "..... I got ripped off in the summer and I was straight back there. [*I said - to a person buying drugs*] You know you were asking that bastard so and so, he's just ripped me off three amps. Two nights later I'm up there and he had a real go at me over it, and I said well you ripped me off and I'm going to tell everyone about it. And he tried to deny it. He gave me back one of the three and I'm still waiting for the other two and I keep on at him. I've told him I won't ever buy off him again. The thing is I created so much hassle for him, and I still remind people that he's a rip off artist. He won't ever live it down. Anyone rips me off they don't live it down." (c3).

This is a good example of how the network could be used to sanction antisocial behaviour. This woman may not have had the ability to be physically intimidating, but spreading information that damaged a dealer's credentials had enabled her to achieve some recompense. The following section outlines participants' perceptions of harm reduction information exchange in the network.

5.4 Information exchange in the network

As already suggested, information exchange between clients tended to be about drug availability. As one man said:

> "To be truthful, the majority of times you come here.... you talk to people in here

and it's just who's got what." (c4).

In general, participants did not source safer drug using information to other clients although this kind of information from staff was recalled. Accurate, sensible information from staff was contrasted with inaccurate, reckless information from clients. As one participant suggested, the size, transitory nature and kind of person involved in the network meant that misinformation was possible. In contrast, the service was a source of reliable information.

> ".... there's so many new users hitting the street every week or coming down here now, that it would be a crime to see them come down here and get information off some of the scumbags out there instead of being allowed to get it in here..... 'Cos they're [*staff*] not going to do anything that'll fuck you up. Whereas there's people out there that'll just tell you it for the sake of telling you it. No matter of the outcome..... The information you do get in here is essential to a new drug user because it's accurate, such as on safe using sites, breaking down amps, filtering tablets and stuff like that. You know, stuff that some people just don't think about." (c6).

A staff member also suggested that information passed between clients was not always correct. She indicated that dangerous practices, such as groin injecting, may become acceptable among groups when one person apparently is able to do it without negative consequences.

> "You see people coming in who have had all their injecting advice from other clients, and some of it's very wrong and damaging..... It's our responsibility to pick up those pieces and put people right. One of the biggest ones we come up against is injecting in the groin because you'll have maybe one person who's been doing it successfully for years and years, but they are the exception to the rule." (s3).

Although harm reduction information exchange may not have been a defining feature of the network, one participant recounted a piece of safer using information he had imparted to another drug user about the dangers of mixing opiates and alcohol.

> "I was talking to a geezer the other day and he was going, "I've got to have a lager and I'll have a bang up [*inject drugs*]".... Get drunk and have a fix, the chances are you'll go over - overdose.... So I told that to this guy.... and he said, "yeah yeah, you're right really".... That's happened to my mate. He was drinking and he died." (c4).

Another said she enjoyed being an information provider and would correct misinformation, indicating how providing or being seen to provide information may relate to self-image and esteem.

> "I tend to do it a lot because I'm that sort of person. I love imparting knowledge. That's why I want to be a teacher. I can't help myself. If I hear someone saying something that I know is totally out of order or totally wrong, I will tell them." (c3).

These quotes illustrate that information exchange related to safer drug use did occur. The fact that giving information was recalled, as opposed to receiving information, is interesting to explore, although it may be a particular feature of the sample in this study. The kind of person who agrees to take part may also be the type of person who dispenses information to others. It may be also be easier to recall giving information rather than receiving it. As the quote about the dangers of overdose illustrates, the information did not appear to be imparted outside a normal interaction between two people. In contrast, it could be argued, information received from staff would be easier to recall since this occurs within a differently defined relationship. A third reason could be a consequence of the demographics of the clients using the service. Participants said that they had received advice from more experienced drug users when they first started injecting. In the context of talking about the lack of good peer informants around safer drug use at the service, one man said:

> "I was fortunate that when I first started hitting up I had a good teacher who told me never to share works. This was before AIDS really hit the headlines. He told me never to share works, always to try and use new works if I can, and always dispose of works properly..... He was a good teacher in that respect and he'd rather go sick [*withdraw*] than have a hit with someone else's works or a dirty works." (c6).

This story was similar to others, initial injecting facilitated by a more experienced drug user or mentor. Methadone use, particularly injectable methadone, usually follows heroin use and heroin is not regularly dealt in the local area. Therefore, many of the clients using the service may have learnt to inject in a different context. By the time they had accessed the dealing scene around the service they were already quite experienced drug users. Although there were suggestions that younger less experienced users were beginning to use the drugs available in the area without the

history of prior heroin use, the drug using experience of the clientele in this network may constrain the dissemination of drug using related information.

A final reason that giving rather than receiving information may be easier to recall, is that there may be some kudos in being perceived as an information provider. It reflects a certain maturity, it may be a way of defining oneself in a positive way and therefore related to self-esteem and may also be a way of seeking approval in the context of the study interview.

5.4.1 Summary: Information exchange in the network

Information participants recalled receiving from other clients tended to be about the availability of drugs. Good quality information from staff was contrasted with inaccurate or reckless information from other clients. However, some of the participants recalled giving harm reduction related information to others suggesting that it may be easier to recall information for a range of possible reasons.

In the following section, the distribution of unused injecting equipment gained via the service (secondary distribution) to other drug users is outlined as a specific harm reduction communication and one that has been seen to occur in other drug using networks (Power, 1996).

5.5 Secondary distribution of injecting equipment

Two of the participants regularly distributed injecting equipment to other drug users in the market. Their stated motivation was a concern for other drug users' potential for unsafe injecting. For example, one man said,

> "The amount of times I've come out of here with boxes of stuff and like ended up being like a needle exchange up at **** Road, because I don't want to see people use dirty works." (c6).

Another regularly carried more than she needed with her to ensure that she could provide others with sterile injecting equipment.

> "If someone's short and I've got works, I would always give them clean works rather than have them sharing or using dirty works. I always carry more than I need to do that ....." (c3).

She had incorporated this behaviour into her acquisition of injecting equipment routine, taking more than she personally required so that she could give some away without running out herself.

> "I will always give them away because I always get a lot anyway. I normally get 200 or so at a time. I'll always bring out at least half a dozen or a dozen with me because even if I'm not going to use them myself.... I know I'm going to come across a couple of people who haven't got anything. And I'd far rather give them away even if it means me slightly short for that moment, because I know I've got more at home, than have someone risking their lives using someone else's." (c3).

Another participant said he would curtail his own drug use if a friend required a sterile set of injecting equipment. For this man, concern about a friend's drug using behaviour was more important than using all the drugs he may have had.

> "If I've got 2 new needles and 2 new works left and I've got 3 amps and the geezer's desperate to have a hit, he'll get a new set of works. It don't matter whether I have to go without. I only have to have one hit that night and have to go without till the morning. That wouldn't bother me. But I would never let a mate use old works if I've got new on me." (c6).

He suggested, in contrast to himself, that when there was poor availability of injecting equipment, there was considerable variability in how drug users would adapt their behaviour. Secondary distribution was therefore perceived as very important.

> "There's a kind of essentiality to it [*secondary distribution*] in respect that, like at 10 o'clock at night when there ain't no place else to get works, but you know people that have got them, used ones and that.... you don't know what they're capable of or what they're prepared to do to get their hit." (c6).

Although these quotes indicate that secondary distribution is an altruistic act, it was suggested that it could also be a source of income.

> "You get a few people that if they're really hard up they'll sell it. You know, I'm really broke, can you give us 50p. And if someone is a bit hard up, then you don't mind." (c3).

5.5.1 Summary: Secondary distribution of injecting equipment

These quotes indicate that secondary distribution occurred among participants and within the local drug market. This may be due to altruism, an act of friendship, or a way of making money. Whatever the reasons, it can be seen as a positive harm reduction communication, facilitating safer injecting. The value of this behaviour is explored further in terms of developing peer interventions from the service studied.

5.6 The drop-in

As indicated in Chapter four, the drop-in existed as a particular space within the service where interactions of a particular quality were facilitated. The boundaries, maintained by the staff, defined the space as safer and different from the market. Despite these controls, many of the participants felt that the contact with other users in the drop-in was still related to drug purchasing and it was used as a convenient meeting point for dealers. However, one woman said that the drop-in was a useful space in which to pass drug related information.

> "Yes, if people can sit together and chat then you do pass on information. You pass on information about who's ripping people off, who's got good drugs, who's got bad drugs." (c3).

As described earlier, she had used the network to achieve some recompense from a fraudulent drug deal and the drop-in existed as a place within which these issues could be discussed. In addition, she indicated that the drop-in had been used to discuss safer drug use issues and had herself imparted information to others.

> "A couple of times when we used to have the drop-in here all the time. And I'd join in and I'd say, well actually I don't think that's quite right. I've always understood it to be.... I always try and put it politely." (c3).

In the final section of this chapter, the implications of the findings outlined for the development of peer interventions are considered.

5.7 Developing peer interventions - issues to consider

The structure of the market and the fact that drug dealing is the basis to the interactions between clients, appears to constrain the extent to which the network could be utilised to advocate safer drug use. However, despite this there were indicators of behaviours and attitudes that could be understood in terms of positive harm reduction actions and beliefs. Building on these would be a relevant starting point to develop peer interventions in the network. One issue which may be both constraining and enabling is the real or perceived change in the demographics of the clientele. Older users are perhaps more stable and mature, whereas in contrast,

> ".... a lot of the youngsters, because they've got such a gung-ho attitude to things anyway that they're.... you know, an older person is more settled mentally, I've found, whereas younger people are very erratic. Obviously you get the very erratic ones that are older too, but a lot of people that are like that don't live too long. Most of the people that I've known well like that are dead." (c6).

Consequently, older users may have useful experience to impart to younger drug users.

> "The older lot are the type that have lived through a lot of the stages that they see in a lot of people down here.... I don't give a shit, I don't care if I die or whatever kind of attitude, and they've come out the other side. All right, they've got no veins left, but they're still alive and they're still using. So that's got to say something. So in many respects the older lot can give you advice that is essential because they've been there and they've done it." (c6).

As an older user, this quote may be an example of this participant's own beliefs about himself. If older users are more experienced, self-reflective and concerned about others, they could be valuable peer informants. However, to take this man as an example, his age may define him as different from his younger drug using peers and reduce the salience of his advice. This is indicative of the danger in assuming a notion of peer or community on the basis of people's behaviour. Within any group of people who engage in similar behaviour, there are likely to be differences, and age seems to be significant. Another quote from a participant further highlights these issues; in relation to discarding injecting equipment in the street and in contrast to herself:

> ".... young people haven't thought about it properly. Really what they need is to be sat down somewhere with a few older people like me and some of the others around who've been around a long time, who can explain to them why it's not a

good idea to throw things around." (c3).

She assumes that her experience would give her advice credibility. However, this fails to take into account the possibility that her age may actually be a hindrance in imparting information particularly in the form of the lecture-like quality of her suggested intervention.

A second issue to consider is the older participants' negative perceptions of the younger clientele, as outlined earlier in this chapter. This hostility, reflecting a possible desire to distance themselves from others and their negative behaviours in the network, could impact on their approach to the "young people". Addressing older users' attitudes to others and their approach towards imparting information to others would be necessary if they were to be recruited as peer informants. Even if older users may be easier for staff to engage as peer informants, it does not mean that they are the key people within the network. If the network is evolving as suggested, peer informants and the strategies for intervention may also have to change over time.

The occurrence of secondary distribution could be one behaviour which the service could facilitate. However, a number of points need to be clarified. First, the function of the behaviour for the distributor. There was a suggestion that financial gain may be a factor which could be potentially problematic. Secondly, the impact on new clients accessing the service. This should be considered in relation to the finding that the staff are perceived to have good quality information in contrast to clients. However, it could also be argued that secondary distribution could act as outreach and raise the profile of the service in the network. Finally, the implications for secondary distribution on the relationship between the service and local community and the effect on returns of used equipment to the service would need to be carefully considered.

Another aspect to consider from these findings is the role of the service within the network. As outlined in Chapter four, the drop-in provides clients with a space in which they are able to interact relatively safely. One of the participants, who said she had tried talking to people about anti-social behaviours, felt she had been restricted by interacting on the street.

> "I've tried it with a few people. Sometimes they're just too out of it to care, sometimes they just don't want to know.... you know because I'm doing it out on

> the street trying to explain to them why, and they're walking along and they're in a hurry. You can't do it like that. You need to sit people down over a coffee or whatever and say, look it's not cool for the neighbours, it's just going to make this place get closed down." (c3).

This indicates that the drop-in offers more suitable conditions in which these issues could be discussed and from which peer intervention projects could be developed. Using this space to develop a consensus about what constitutes anti-social behaviour, including that around dealing, could be a useful avenue to explore and may foster a more positive community identity within the network. Developing a community identity and becoming involved in these discussions and interactions could also be viewed positively in terms of self identity and, therefore, safer drug use. This issue is explored further in chapter eight, but as Holland's (1992) work suggests, shifting the causes of a problematic behaviour from within the individual and understanding it in a social and political context is an important part of people gaining a sense of collective power actively to change their circumstances. As discussed in Chapter one, drug user collectives, acting as pressure groups for policy change already exist. At a more local level, involvement could foster a sense of community, could empower individuals and could be facilitated within the service to encourage some form of self regulation and safer drug using norms among the network.

The issue of developing peer based interventions in the service as a way into the local drug market is complex and only a few of the issues necessary to consider are raised by the findings of this study. However, the service is a potential venue in which these ideas could be considered further in relation to picking up on changes in the demographics of the network, reflecting on the most suitable interventions, as well as a base for piloting and evaluating peer led projects.

5.8 Conclusions: Client interactions

The communication most central to contact with other clients centred around purchasing drugs; this constrained the extent to which the network could be described as supportive. Supportive interactions were more likely to occur among small numbers of individuals. In a more positive vein, instances of harm reduction communications, including secondary distribution and safer

drug use messages were reported. These findings raise a number of issues in relation to peer interventions. Understanding the complex dynamics within the network is likely to be important in the successful implementation of a project at this level.

In the next chapter, participants' contacts with family and friends and their perceptions of pharmacy exchange are considered. This provides a context to the way they used the service as a source of support.

Chapter 6 Analysis: Family, friends and other contacts

6.1 Introduction

This chapter outlines participants' views of their contact with non-drug users. It gives some indication of the extent of their support networks and provides a context to the meaning of the interactions described in Chapters five and seven. Participants' perceptions of pharmacy needle exchange are also included in this chapter since the core function of these is the same as the service studied. However, the way interactions with pharmacists are perceived reveal particular valued aspects of the service studied and provide a further context to the interactions outlined in Chapter seven.

6.2 Family, friends and social support

All the participants who had contact with non drug users described a difficulty in maintaining relationships and drug use. Consequently, they kept the extent of their drug use hidden or separate. For example one man said:

> "I've got me missus.... I've got a little boy.... She don't use, my missus don't even have an aspirin when she's got a headache. She don't do nothing, don't smoke, don't do nothing. She don't know about how deep I am in it all." (c4).

He thought that keeping his drug use hidden from her was deceitful and consequently detrimental to their relationship.

> ".... relationships are built on trust and - not lying - but when you continue lying it affects the relationship. You know, you're not being open. I couldn't be open with my missus." (c4).

This man was seeking respite care at the time of this interview and it is therefore likely that he would be particularly aware of the negative consequences of his drug use. However, his perceptions illustrate how drug use had to be kept separate to maintain an intimate relationship with a non-drug user. This "lying" could be seen as reducing the supportive quality of the relationship. Another married man was also aware that his drug use was damaging to his

relationship,

> ".... basically my missus can't stand me when I'm high and it's unfair to put her through the stress that I do put her through, 'cos like, one of the things that go with drug use is severe mood swings.... I'm not the person she fell in love with kind of thing. There might as well be a stranger in the house when I'm there and I'm out of my face." (c6).

However, he had developed a strategy to manage his drug use and maintain the relationship which involved negotiated time out to use drugs.

> ".... she don't see me for a few days and then I go home straight. I'm home for a couple of months and then I maybe do it again. It's an agreement we have that if I feel the need to use, it's better that she knows that I'm going there to use and then I'm going to come back straight.... like an escape - my chance to escape without it destroying the relationship in the process." (c6).

Although this man had developed a strategy to protect his marriage and use drugs, it is notable that he could do this only by separating the two.

Another participant felt that, although she could talk to her mother about her drug use her understanding of it was minimal.

> "..... I can talk about some things to my mother but she doesn't understand. She just says, 'I'm glad I don't have to go through all that palaver'." (c3).

Apart from one sister, her family were also unaware that she undertook sex work to fund her drug use. Similarly, another participant protected his father from knowledge of his drug use.

> ".... A few years ago he found out and wasn't happy at all, but he doesn't know I do it any more. I don't want to upset him." (c5).

These quotes add to the theme that the reality of the participants' drug using lives had to be kept hidden to protect and/or maintain relationships with family and partners. As well as family, drug use was also perceived to cause problems in relationships with non-drug using friends. The youngest participant, who described people he met in the service quite positively, made a clear distinction between these people and friends he had longer-term relationships with. However, only one of these people used opiates and consequently,

> ".... I don't see them that often. It's only my mate that uses opiates that I hang out

> with really.... They don't like it if I go round there and I'm stoned. They get pissed off." (c5).

In addition to family and friends, work related contacts were explored, although none of the participants was employed at the time of the interviews. However, one had recently lost his job as a chef in a restaurant because his employers had found out about his use. He wanted to get back to work but felt that drugs were central to his life.

> ".... I would like to quit it all so I could get back to and really concentrate on my work, but it's hard, it seems to me virtually impossible. It's like [*drug use is*] part of my life." (c5).

These accounts describe how contact with support networks could be maintained only by keeping drug use secret. Where this was not possible there was felt to be a lack of understanding from non-drug using family and friends and/or an increased sense of withdrawal and isolation from these potentially supportive relationships. This marginalisation from support structures could be understood to be a consequence of dominant ideas about the unacceptability of drug dependence and injecting opiate use.

The significance of these accounts in terms of safer drug use is complex. The importance of social support as a protective factor in maintaining mental wellbeing is considered within models of community psychology (Orford, 1998). Moreover, various indicators of mental distress are associated with unsafe drug using behaviour (Strathdee et al., 1997). Thus the absence of social support could be seen as a risk factor in unsafe drug using behaviour.

These accounts give a context to the way that relationships with staff in the service were perceived and utilised. In the next section the participants' view of interactions with pharmacists in the context of needle exchange are considered as these indicate particular aspects of the service which are valued and the kind of interactions which are sought.

6.3 Perceptions of pharmacy exchange

Most of the participants had also used pharmacies to obtain injecting equipment. Some felt that their interaction with pharmacists had been limited and different from their contacts with staff in the needle exchange. For example, one man thought:

> "..... a lot of the chemists now do the needle exchange system, but it's not the same. You don't get the verbal support which is essential really. When you go into a chemist and you go, "Can I have a 5 ml pack please? Goodbye." That's the end of it." (c6).

He expressed a need for additional support, and in contrast to the needle exchange suggested that pharmacists are:

> "..... basically only doing the service to prevent the spread of disease, but they really don't give a shit about you, they don't give a crap. They'd rather you didn't have to come in there and get needles, obviously. Like that lack of caring, that cold - it is, it's a coldness really, it's a non-understanding of why a lot of us are like what we are. I mean, I didn't start using because I liked starting to use, I had my problems and all. I was abused by my brother and everything." (c6).

Another man said:

> "The chemist in the pharmacy hasn't got time to talk to you. A lot of people are on the streets here, they come in and have a nice cup of coffee or an orange juice, they'll sit down and have a chat. You can't go into a chemist and sit and have a cup of coffee and start bitching about what's been going down." (c4).

These quotes highlight that pharmacies were not perceived to be places where they felt welcome, could receive verbal support or spend time. They also indicate that some of the participants felt that pharmacists did not understand that they may have problems. In contrast, the service studied offered support and understanding as well as a place to interact with other drug users.

This negative view of pharmacy exchange may have been due to the participants being clients of the needle exchange and, as such, it would be expected that they valued elements of this service that were not part of pharmacy exchange. People who regularly used pharmacy exchange may have given a different response. The anonymity, brevity of the transaction and absence of other

drug users, might well be desired factors in choosing a pharmacy over the needle exchange for other drug users.

These accounts indicate elements of the service which were valued and the desire for communications that could be considered supportive.

6.4 Conclusions: Other interactions

While this study did not make a comprehensive assessment of participants' support networks, professional and otherwise, there was a general indication that contact with non-drug users and professionals, other than the staff in the needle exchange, was minimal. Of the participants who maintained relationships with friends and family, there was a sense of needing to keep their drug use hidden or separate. This could be seen as increasing the possibility of social isolation and withdrawal from potentially supportive relationships. The perceptions of pharmacy exchange are interesting as they begin to indicate aspects of relationships with staff in the service studied that are valued. These are described in the following chapter.

Chapter 7 Analysis: Interactions between clients and staff within the service

7.1 Introduction

This chapter outlines the client participants' perceptions of their relationships with the staff in the service studied as well as the staffs' description of their working approach and interactions with clients. A number of themes emerge from these accounts. They are considered in relation to the supportive functions these interactions may serve and in terms of some of the ideas underlying motivational interviewing. These concepts are used to reflect on how the interactions described may be significant in enabling people to maintain safer drug using behaviours. It is useful to contextualise the quality of the interactions described in this chapter with participants' accounts of their contact with pharmacies and treatment agencies as described in Chapters three and six.

7.2 Clients' experience of their interactions with staff

The client participants in this study, particularly the longer-term clients, described their interactions with staff at the needle exchange in positive terms. The themes that emerge from their accounts reveal processes by which these relationships are facilitated. I have conceptualised these as engagement strategies. The functions of these relationships in relation to support and self-esteem are also considered.

7.2.1 Perceptions of similarity to staff

In Chapter four, participants indicated that there was a value to being able to express the difficulties associated with drug using and being understood as a drug user in a non-judgmental atmosphere. The service studied appeared to be a unique space in which this could occur. Being understood as a drug user also emerged in terms of interactions with staff. One participant thought that the staff understood her because they had been drug users themselves.

> ".... they're [*staff*] people who've used drugs in the past a lot of them, and because they're working with drug users, they know about it, so I can talk to them." (c3).

Interestingly, this was not an accurate perception of the staff and therefore may say more about the staffs' working approach and/or the client's wish to perceive them in this way. Developing this second point, she said:

> "It's important for everyone to have someone you can talk to, someone you can relate to." (c3).

Perceiving the staff as similar to her, facilitated a sense of being understood and was contrasted with her experience of contact with workers in other agencies who

> ".... come out with so much crap - they haven't lived it themselves. Like you go along to the homeless persons unit. They've never been on the streets, they've never been homeless, they don't know what it's like." (c3).

A quote from another participant suggests a similar process of minimising the difference between himself and the staff.

> ".... these [*staff*] are people that really are no different from any of us - it's just that we're junkies really I suppose." (c4).

Invoking the concept of junkie in this context is interesting since participants generally preferred to talk about themselves as drug users as a way of distinguishing themselves from other users of the service. This minimisation of difference between self and the staff highlights the possible occurrence of perceptual and interpersonal processes that serve the function of facilitating the development of relationships but may also be important in relation to self-esteem. These ideas are developed further below.

7.2.2 Feeling accepted by staff

Another quality of participants' interactions with staff that emerged was a feeling of being accepted. This meant not being stigmatised or judged negatively because of drug using behaviour. One woman said:

> "If you're using drugs, you still want to be treated like a human being. And when you come here, you're treated like a human being, whereas you go to some other places you're not. Just like scum." (c3).

Another participant said that feeling accepted enabled communication.

> ".... knowing that there is someone there that you can talk to, that's not going to treat you like you're the scum of the earth. Not going to be biased towards you because of what you do...." (c6).

Respecting people's self determination in relation to drug use was another aspect to being accepted. For one participant the service, in contrast to others, was

> ".... somewhere that doesn't try and get you off the drugs either. They don't hassle you and say, don't you think you should think about going off to a detox, which I have had in the past." (c3).

In contrast to interactions elsewhere, participants described being accepted despite their drug using behaviour and not being coerced into changing these behaviours. The importance of this can be understood in relation to the theory on which motivational interviewing is based. A non-coercive approach creates the conditions in which ambivalence about drug use or drug using behaviour can be explored and minimises client resistance (Miller and Rollnick 1991).

Feeling accepted can be seen as facilitating engagement with staff, may be positive in terms of self-esteem and part of creating the conditions by which these relationships could be perceived as supportive.

7.2.3 Perception of relationships with staff as special

A third theme that emerged from participants' accounts of their interactions with staff was that their relationships were somehow special. Partly this was achieved by differentiating themselves from other clients, for example:

> "The staff up here have done a lot for me and him, because I think they like us really because we're not rude, you know." (c1/2).

There is the suggestion from these participants that their difference from other clients meant that they were liked; this was why they had been helped rather than because the staff were doing their job.

> "She like helped me and him. She showed us respect.... 'Cos I can't understand

> why you lot work with people 'cos some of us, I'm not saying like me and him, are ignorant, foul, have got no respect." (c1/2).

This quote also indicates a sense of mutuality and respect in the relationship. In addition to this, these two participants also wanted to define their relationship with a staff member as different from a typical professional / client interaction.

> "Basically I used to enjoy talking to her. She's on the same wavelength."
> "All you lot are in there. You all know the score. I mean it's not as if you're [*referring to the interviewer*] - I'm only doing this like for a project. You all know the score you know."
> "I don't class myself as a junkie. We're drug addicts." (c1/2).

Their perceptions indicate a number of possible processes occurring together. They thought that the staff member interacted with them because she liked them and they shared similar attitudes; they had a perception of similarity and feeling special. They also thought that the staff were working in the project because they "know the score", implying a sense of vocation in choosing the work. And by invoking the junkie / drug user dichotomy their difference from other clients was stated and by implication their similarity to the staff. (The junkie / drug user dichotomy as a part of self identity is discussed further in Chapter eight).

These quotes indicate how some of the participants wanted to minimise the difference between themselves and the staff, while distinguishing themselves from other clients. This enabled these interactions to be defined as special relationships outside of a normal professional / client discourse. Again these perceptions can be seen as potentially esteem building and as facilitating engagement with the service. The theme of relationships being defined outside of typical professional / client interactions is considered further below in terms of "normal" communication.

7.2.4 "Normal" communication with the staff

Participants frequently described their interactions with staff in terms of chatting and talking. I refer to this as "normal communication", to convey the sense of an interaction based on social rules not associated with a client / professional relationship. Although these interactions were

described in everyday terms, they were also valued and actively sought. For example, one man said:

> "The fact is I come down here sometimes just to come and have a chat. Today I come down because I wanted to score, but I normally just come down to come in, and not get needles." (c4).

The staff were perceived as people who made time and were easy to talk to, suggesting minimal barriers to these interactions.

> "Basically they were easy to talk to. Even when they were busy they didn't like give you the brush off and say, not now, not now, I'll have to talk to you another time, or anything like that. They would still find time to talk." (c3).

Normal communication sometimes meant non-drug related conversations typically about football. The following quote indicates how these interactions could serve the function of maintaining a positive self image and as a means of differentiating the self from other drug users. Note the use of junkie in this context.

> "The average junkie all he wants to talk about is drugs. And I'm not into that. There's more to life."
> "I can talk about football, we can talk about other things." (c1/2).

Another aspect of normal communication was being able to talk in an open way about the difficulties of a drug using life. Key quotes to illustrate this are outlined in Chapter four, indicating the importance attached to being in a space where aspects of a drug using life could be expressed openly. The value of this can be understood in relation to the limitations that being a drug user places on interactions with family, friends and other professional networks. Normal communication about the realities of a drug using life can be seen as an opportunity to express ambivalence about it. This might be important in relation to processes of behavioural change and maintaining safer drug use. This aspect of normal communication also potentially facilitates a feeling of being accepted, within a wider context of drug use being unacceptable.

7..2.5 Summary: Normal communication

Normal communication can be understood in terms of talking about non-drug related issues and may be an indication of a process of identifying with staff and distancing from clients which has

an esteem building function. However, it may also be understood as being able to talk openly about aspects related to drug using in an accepting and supportive relationship.

7.2.6 Perceptions of staff as carers and idealised people

A final cluster of themes that emerged from the participants' accounts were the staff as caring, good people. Emotive statements about the value of their work were linked to a perceived caring attitude. For example one man said,

> "We're the users and these people want to help, which makes them that better class of people than the average man in the street in my eyes, because they're doing something for me. If that weren't done there'd probably be twice as much AIDS on the street, twice as much disease, three times as many people dropping dead." (c6).

He also thought that the staff,

> "By them telling you [*advice about tolerance*] at least they've done more than what they need to do really.... but that kind of thing isn't something I would suppose is part of their job description. I think it's just the decency of the people that work here." (c6).

Another suggested that, even though they got paid, the staff were doing their job because they care.

> "Now the people who work here have to have money to live but unlike the fellow working on the building site, they are people that actually do care about their clients. That's the feeling I get." (c4).

These quotes indicate how the basic staff role was perceived in non-professional terms. Advice and caring were attributed to personal qualities of the people who worked in the service. The meaning of this is interesting to consider. These positive perceptions may be a consequence of the negative interactions some of the participants experienced in contacts with other professionals. Hence there may be a desire to construct the meaning of the relationships with the staff in different terms, more related to personal rather than professional qualities. These quotes may also be an indication of the importance ascribed and supportive functions of these relationships. As one man stated:

> "Whereas society is so cold, and to get that warmth from somebody or a group of people that really don't owe you nothing, or anything like that, makes all the difference." (c6).

Another man indicated the importance of these relationships in the context of his experience of negative interactions and sense of being alienated.

> "It's almost like I come down here and I feel like the moment I walk in.... that street it's uncaring.... and I come in here I feel that actually people do actually care for me." (c4).

7.2.7 Summary: Perceptions of staff as carers and idealised people

Perceiving the staff as caring people whose work was based on a personal commitment to the job, rather than a professional role, may serve a number of functions. It could be an attempt to define the relationship as different from the experience of negative interactions with other professionals, but also as a means of conveying the importance attached to these relationships. It could also be a way of giving meaning to feeling contained and supported in these relationships. Finally, it could also be seen as serving the function of facilitating engagement with the staff in the project. In Section 7.4, the functions of these perceptions and how they may be significant in facilitating behaviour change are further considered, but first the key interactions arising from staff interviews are outlined.

7.3 Staff: Working strategies

The staff spoke explicitly about a working approach that facilitated engagement and the development of relationships with clients. As outlined in chapter three, in contrast to treatment agencies, not being involved in prescribing enabled these interactions. The staff thought this was due to the absence of a power imbalance. In describing a working approach, it is notable that the themes that emerge are congruent with those from the clients' perspective outlined above.

7.3.1 Acceptance, non-coercion and a positive approach

One of the staff said,

> "I think one of the most important things we try to promote here is that experience of being non-judgemental". (s2).

Another said this involved an acceptance of clients' drug using behaviour with an emphasis on personal choice in changing these behaviours.

> "We're very accepting in lots of ways that what they do isn't particularly safe and isn't necessarily the right choice for them. But we also accept that if they're armed with all the information that they need, it's OK for them to make those choices". (s1).

This quote indicates the non-coercive approach of the staff. The rationale for this was that,

> "You've got to have a good relationship with somebody if you want to be able to make suggestions about how they can change." (s2).

Part of developing a good relationship involved maintaining a positive attitude towards the clients which can also be considered as a further strategy for engaging and facilitating interaction.

> "My thing has always been to be very positive when anybody walks through the door, anybody at all, and sometimes that's really difficult." (s2).

A simple example was:

> "Eye contact at the door, a cheery hello. It sounds so cheesy, it sounds all very P.R...." [*but*] .... people will actually take a step back. 'Ooh hello'. Like nobody's said hello to them for days." (s2).

In addition to building a relationship within which suggestions about changing behaviour could be made, the rationale for this approach was:

> "anything you do creates a rod for your own back. So if you're negative with people, they'll be negative with you, and then you get into difficulty." (s2).

She described difficulties in maintaining this approach and said that it also involved negotiating within the staff team about how to work with particular clients.

Aspects of the staffs' working style can be characterised by seeing clients as active parties in decision making around their drug use, not judging clients for their behaviour and maintaining positive interactions despite chaotic client behaviours and challenges to this approach. Interestingly, what staff described as a pragmatic working style was perceived by the clients interviewed as being a consequence of their humanity and not as professional behaviour.

7.3.2 Working with boundaries

As outlined in Chapter four, the issue of staff setting boundaries was raised in relation to maintaining a safe environment while also wanting to facilitate clients' access to the service. The way that the clients interviewed perceived their relationships with staff suggests that there was also a desire on their part to minimise the perception of professional difference and boundaries. In chapter three, the issue of power and control is considered which may also be thought of in terms of boundaries. Therefore, it is perhaps not surprising that the way boundaries were enacted in interactions with clients was a significant theme that emerged from the staff interviewed and can be seen as a particular characteristic of their working approach.

One staff member recalled interactions that challenged her professional boundaries. She said that some of her clients perceived her more as a friend than a worker. This is consistent with some of the clients' accounts. She said:

> "people have come to regard me as not a worker, more as a friend. And that's a fine line, that's a difficult line. It's difficult not to cross that. People have given me their addresses, they'd like to meet me in the future. And I can't do that because at the end of the day I'm always a worker, they're always a client. You mustn't let those boundaries blur." (s2).

Despite acknowledging the importance of maintaining these boundaries in her professional role, she went on to say:

> "I've always found it makes working a lot easier if someone thinks you're a friend. If that's how they feel, that's OK." (s2).

This indicates that the blurring of professional boundaries may be a two-way process by both

clients and staff. This staff member was explicit about this transgression of her professional boundaries, formulating it as a particular strategy:

> "you almost have to go a bit more than halfway to get through to some people. And then you have to retreat as well, back to behind your line." (s2).

This was perceived as difficult and not without unwarranted consequences.

> ".... it's a balancing act a lot of the time, in terms of giving unconditional positive regard but without somebody then thinking they can tell you how gorgeous you're looking." (s2).

She managed this through a clear restating of her role as a worker, while also validating the positive nature of her relationship with the client.

> "My get out is always re-establishing the fact that I am a worker and they are a client. That can seem a bit harsh and it can actually put them back a little bit, but to be quite blunt, you say to somebody, look this is my job. I have a relationship with you because that's my job. But at the same time I like you as a person as well. Don't push it, because otherwise I won't want to work with you. It's all negotiation." (s2).

This quote indicates the complexities of her work. Implicit negotiation around boundaries requires insight into the dynamics of the relationship and acknowledgement of the difficulties some of the clients may have experienced in contacts with other professionals.

To some extent these quotes suggest a certain anti-professionalism, a rejection of professional boundaries. However, this staff member had a clear conceptualisation of the meaning and importance of boundaries but at the same time was able to allow a certain amount blurring of these in her interactions with clients. This can be seen as a strategy for forming and maintaining relationships and also as part of the way the service was identified as different from other services. The following quote is a good example of the complexity of maintaining boundaries. It is an insight into the dynamics of interaction and negotiation among the staff team; the reluctance to invoke sanctions that could exclude clients and how the relationship was used to restate a boundary without using professional difference and power. She gave an example of a person who made a sexual comment to her. The only clear sanction on a client's behaviour is a ban from using the service. However, she felt it was better to address the issue in the context of the relationship

rather than punish the behaviour, despite other staff members' opinions.

> "There have to be very definite boundaries, but, for example, somebody made quite an inappropriate sexual comment to me a couple of weeks ago and everyone else was up for banning him. And I was like, well hang on, I'm the one who was on the receiving end and I don't think he should be banned. I told him at the time that was out of order, and if you ban him that's actually not going to really get us anywhere because he'll be back in 2 weeks or a month and do it again. If that's the worst we can do you've got no sanction, whereas if you say to him as a human being, I'm really offended, do you mind not talking to me like that. You bring it back to the human level rather than a parent child which is very easy to get into." (s2).

7.3.3 Summary: Working with boundaries

Understanding and working with boundaries was a central theme in the working practices of the staff. There was a delicate balance between maintaining professional distance and engaging with clients. Relaxing professional boundaries was one way to engage clients, but the consequences had to be carefully managed, not only in terms of clients' behaviour but also in terms of the feelings invoked in the staff. The sensitivity to this issue was also apparent in the belief that some of the clients may have had negative experience of boundaries, particularly from other professionals and/or an absence of boundaries in aspects of their lives (see Chapters three and four).

7.3.4 Normal communication as a motivational strategy

Like the clients interviewed, the staff also talked about normal communication. Staff had a simpler idea about normal, that is non-drug related, and

> "showing the client how to interact with somebody on a level that doesn't have anything to do with negativity." (s1).

Staff conceptualised these interactions as explicit strategies with the aim of giving clients respite from drug related issues and modelling an alternative way to interact. As one staff member said:

> "Some of the most valuable work that we do here in some ways doesn't have anything to do with drug use." (s1).

He went on to say that talking with clients about football, as opposed to drug use was normal, or perhaps importantly "perceived as being normal" by clients. The value of this he suggested was that

> "for some clients the only place they get that kind of interaction with people is with us. The only people that they know who aren't drug users are us ...." (s1).

This is a possible indicator of an important social support function. He also implies that the value in these normal conversations is that it provides clients with a glimpse of normality which then acts as a motivator to change drug using behaviour.

> "For some clients they experience that and sort of think, hey actually I actually quite like this, this is like normal, this is what normal people do. And it gives them a sense of what it's like to be part of the real community as opposed to being part of their own subculture which is always geared towards one thing [*drug use*]" (s1).

This can

> "set up a train of thought in a client, it can set up a goal for them in their own mind. I'd like to have more of this. To get more of this I need to get myself more together. I need to cut down my drug use. I need to stabilise on my drug use. Then I can have these kind of conversations more often." (s1).

The assumption in this quote is that drug use is negative and normal communication is positive. This is further illustrated below.

> "A lot of it is deflective, we're deflecting clients away from the negative parts of their life and trying to talk about stuff that's more positive. And it can be something as fatuous as last night's football." (s1).

The following quote illustrates the insight he had into the relative judgments he was making but suggests that having a link into normal life was important for clients.

> ".... we're a lot of clients' link with the real world, with reality. Because for the rest of their miserable lives as they perceive it, they don't have that. And we are a link. Not a tenuous link, either, a very solid link into the reality of normal life. I keep saying normal life without meaning to denigrate the clients or their chosen lifestyle, but normal as is perceived by the great unwashed public." (s1).

This quote suggests that there exists a construct of normality in society, which drug users are excluded from because of their behaviour. To be part of the "real world" requires keeping drug

use separate which may not always be possible and leads to increased marginalisation. The staff, by providing opportunities for clients to have "normal" conversations (in the context of acceptance of drug use) offer a bridge back to feeling "normal" with the potential benefit of addressing some of the psychological consequences of feeling excluded as well as raising self-esteem. The value attached to these opportunities by clients may be seen in the participants' desire to minimise the differences between themselves and staff and in distancing themselves from their "junkie" peers. This further develops the idea raised in Chapter four of the service as a transitional space, that is one between a drug using and "normal" world in which different aspects of the self can be validated and reinforced.

Another staff member talked about the normality in communication as being a valid intervention with clients. Her rationale was:

> "It's something that's quite limited in their experience of any other interaction that they'll have in their life.... And to the client I may be the only person he can sit and talk about football to. I think there has to be a recognition that drug users have friends, but friendship takes a back seat when there are overriding issues of drugs and money." (s3).

This indicates her perception of the constraints on normal communication occurring in the drug using world and can be understood in terms of the issues raised in chapter three regarding the criminalisation of drug users. This quote also implies the supportive aspect of these types of communication. Extending the idea of normal beyond conversations about football to providing clients with opportunities to share everyday developments, can be seen in a quote from another staff member.

> ".... he might not have many other people in his life that he can tell a piece of good news to or what their plans are..... Let's have some normality in this crazy crazy life." (s2).

The potential functions and importance of these aspects of the staffs' working approach are considered in Section 7.4.

7.3.5 Caring as a working strategy

A final theme to the staffs' working style could be described as expressing care and concern towards the clients. This was defined by staff as a basic human need, providing clients with support perceived to be lacking in other aspects of their lives. However, one staff member suggested that this approach in her work was at odds with her professional training as a social worker, particularly when she expressed sympathy in her interactions with clients. However, from her perception it appeared to work to the extent that it brought clients back to the service.

> "We were always told when I was doing my training, that's one word [*sympathy*] you're never allowed to use. Well I think it's a really important human feeling. If you feel a bit sympathetic and believe in something positive, I think they will come back to you. People do. They come here as opposed to anywhere else. They know they'll get this - tea and sympathy, very important." (s2).

Another said that she got positive feedback from clients by remembering their current concerns and that this was perceived as care.

> ".... someone cares about them, someone's interested in what's happening to them. Because there's a lot of people that come in that are not interested in themselves and what they're doing, but for someone else to make the effort to come over and remember what they said the last time they were there..." (s3).

Her belief was that clients feeling cared for was a first step to them valuing and caring for themselves. This could be seen as important in relation to safer drug use. She also suggested that this served an important supportive function as a substitute for friendships assumed to be lacking in her clients' lives.

> "You've got a relationship with somebody, somebody that cares about you or somebody that shows an interest in you, that might promote you to have some kind of interest in yourself. Some kind of validation of you as a person. If you don't get that anywhere else from other people that you come into contact with. I mean it's a general thing. How many friends do drug users have? They have people they score off, people that they do deals with." (s3).

She qualified these ideas with an example of a client who she had worked with over a long period of time, indicating that her relationship with him provided something different from drug related interactions.

> "**** hasn't got any friends. There's no-one that cares about him as a person. He's only got friends if he's got a script or if he's got something he can offer to somebody else. Whereas the relationship that I would have with him for example isn't about that. It's not about that you can give me and I can give you, physically or materially."(s3).

She felt that caring for clients was important because it was something lacking in clients' lives. In conjunction with normal interactions the supportive aspects of these relationships become a potential vehicle for behaviour change, possibly by raising clients' self esteem or by giving them a glimpse of what a positive and by implication more stable, or even non-drug using, life could be like.

7.3.6 Summary: Client and staff strategies and facilitation of interactions

The themes discussed so far in this chapter indicate particular qualities of interactions as perceived by clients and staff in the service studied. I have thought of these as strategies since they serve the purpose of engaging and facilitating interactions that are potentially supportive, esteem building and motivational. They can be seen as countering some of the aspects discussed in chapter three which had the consequence of excluding and marginalising drug users; the relationships in the service could be seen as being inclusive. These strategies included a rejection of overt professional / client boundaries as a means to engage and interact with each other. Clients perceived staff as ex-users, conceptualised their conversations in terms of "chats" and referred to the special quality of their relationships with the staff. The staff rejected overt signs of professional distance, engaged clients in normal communication and carefully worked with boundaries in these relationships. In the following section the functions of these strategies, perceptions and behaviours are considered.

7.4 Functions of interactions

For the clients interviewed, the functions of the interactions described above can be seen in terms of assisting engagement with the service, raising self-esteem, facilitating the acquisition of information about safer drug use and getting supportive social contact. For the staff, their

approach can be seen as way to engage clients with the service, assist in building relationships which then become a vehicle for providing harm reduction information and various aspects of support. These functions are now explored theoretically with reference to the literature on motivational interviewing and social support.

7.4.1 A theoretical basis to the interactions

The literature on motivation examines the conditions and therapist behaviours that are associated with client behaviour change (Miller and Rollnick 1991). These have been operationalised into a number of therapeutic strategies designed to increase motivation and the probability that behaviour will change (see chapter one). Also of interest is Bilsen's (1991) conceptualisation of motivation as a consequence of four factors, that characterise aspects of the client which need to be enhanced to increase the probability that behaviour change occurs (see Chapter one). Taking a different perspective, both Miller and Rollnick's and Bilsen's work can be viewed in relation to the five functions of social support that Orford (1992) identifies. These refer to the material, emotional, informational, esteem building and companionship aspects of support. Social support by definition, assumes an interaction between someone offering support and someone who is supported. Since interaction is fundamental to motivational interviewing, aspects of the authors' ideas are manifest in these five functions. These various bodies of work are brought together in relation to this study to provide a theoretical basis for understanding the quality and functional aspects of interactions occurring in the service. The ideas are used to explore connections between the functions of the interactions outlined and their potential role in changing and/or maintaining safer drug using behaviour.

7.4.2 Engaging with the service

The functions of clients' understanding of their interactions with the staff, perceptions of similarity, normal communication, perception of relationships as special and feeling accepted can all be seen as facilitating engagement with the service. Similarly, the staff strategies outlined can also be described as facilitating this process. Engaging clients with the service is important in

terms of potentially improving their access to injecting equipment and, as described in Chapter three, access to other services. This may be seen as fulfilling a material aspect of social support (Orford 1992).

7.4.3 Building self-esteem

Clients' perceptions of staff and their experience of interactions can be understood in relation to self-esteem. This is most apparent in identifying with staff as well as distancing from other negatively perceived clients. Bilsen (1991) suggests that self- esteem is the primary foundation to motivation. Although the concept of self-esteem is explored further in Chapter eight, it is considered here in terms of the qualities of the interactions between staff and clients. The staff facilitate interactions that may be significant in relation to self-esteem through flexibility in their boundary setting, providing opportunities for normal interactions and accepting their clients' behaviour. Secondly, from a different and more social perspective, esteem is one of the functions of social support identified by Orford (1992). Aspects of the client's relationships with staff may also therefore fulfil an important element of social support.

7.4.4 Receiving and acting upon information

Ultimately the goal of a needle exchange service is changing clients' drug using behaviour. While it is difficult to attribute changes in these behaviours to specific interventions, some of the clients interviewed indicated that they had acted upon information received from staff to make changes in their behaviour. However, rather than understanding this simply as a consequence of receiving the appropriate knowledge and means (Stimson 1989), I argue that acting upon this information is also a consequence of the quality of interactions outlined above which can be usefully understood in relation to motivational interviewing theory.

Two clients who had been using too large a needle ("greens") for injecting in their arms and not circulating their injection sites were advised otherwise by a staff member.

"We always used to use greens and all. He said stuff them greens, get rid of

> them... Alternate your veins 'cos we always used the same place all the time. I used to have a speed one where I could just bosh bosh bosh and it was done, you know. But that's not on.... we've learnt no end of good information." (c1/2).

Another client said he had changed his injecting behaviour and moderated his drug use.

> "I was banging up in my groin, won't do it no more.... I was doing dexes [*dexedrine*], [*methadone*] amps and that, and I wasn't filtering them right. And I came in here and I was told that it was dangerous and I should filter them [*dexedrine tablets*]. And then they said but it would be better if you don't take them at all. But if you're going to take them, filter them. And that might sound very nutty, I stopped, I don't take them no more." (c4).

Poly-drug use is associated with sharing injecting equipment thus moderating drug use may have had additional harm reduction consequences (Gossop et al., 1993). It is also notable that this participant said that acting on advice might sound "nutty". This would be counter to the Health Belief Model in which acting on expert advice would be logical and expected (Becker, 1974). Although this participant had changed his behaviour on the advice from staff, he needed to qualify that this was not usual for him. This may be understood in relation to possible negative experiences of interactions with professionals in other settings, or as a consequence of the non-confrontational manner in which the advice was given.

The quality of the working approach of the staff in the service could also be described in terms of practising empathy, particularly the acceptance, expressions of care and sympathy. This is a key motivational interviewing strategy (Miller and Rollnick 1991). Miller (1998) reports that high ratings of counsellor empathy are associated with lower levels of resistance and greater and longer-term behavioural change. This can be contrasted with a directive confrontational style likely to elicit resistance. Therefore, it is possible that it is the quality of the staffs' approach which increases the salience of information imparted and the likelihood that it is acted upon. To put it another way, the relationship becomes a vehicle for information provision.

Taking a somewhat different perspective, Bilsen (1991) describes an interaction between self-esteem, integrated and accepted knowledge and behaviour change. Bilsen suggests that, if knowledge is acquired, for example about an unsafe drug using practice, this can lead to a drop in

self-esteem. This may be an aversive experience and lead to a rejection of this knowledge. This process can also be understood in terms of cognitive dissonance and self regulation theory (Miller and Rollnick 1991). It is therefore important that information is given in the context of a relationship that is in itself esteem building. In Bilsen's model, "integrated and accepted knowledge" is the second aspect to his model of motivation. The following quote illustrates this quality to the information provided by the staff in the service studied.

> "Basically, if you come in [*to the service*], if you've just come out of prison and you say, I've just come out of nick, they'll warn you and say, you do realise your tolerance levels dropped and they'll feed you bits of information that are common sense, things that you should know anyway." (c6).

That the information was perceived as "common sense" suggests that it was integrated and accepted.

Returning to Miller and Rollnick's motivational strategies, the quotes from the participants in this section are illustrative of a further set of interventions associated with increasing the probability of behavioural change (motivation). These include advice giving, feedback about the consequences of behaviour and clarifying goals of behaviour change. Both Bilsen's idea of information being taken on in the context of an esteem building relationship and Miller and Rollnick's emphasis on empathy and information giving strategies can be understood in terms of the informational function of social support outlined by Orford (1992).

This process of providing information in the context of a relationship that is empathetic and esteem building may be one of the key ways in which the service influences motivation to maintain / change safer drug using behaviour. It is argued that the salience of this information is enhanced by the working approach of the staff strategies and that it places the information giving aspect of the service within a broader supportive function.

7.4.5 Receiving psychological support

Another function of the interactions described in this chapter is to facilitate relationships that

could be described as supportive, even if they are not defined along typically therapeutic lines. The perception of staff as carers and the caring approach that staff actively tried to convey can be seen as key processes in this aspect of the relationship developing. Participants' accounts of their relationships with staff indicate how conversations described as chats could be psychologically containing and supportive. For example one man said:

> "If you've got a bit of grief, if you're feeling a bit low.... I've been up here when I haven't even brought no gear, and gone in The [*service name*] just to have a chat.... It's somewhere to go. It's good for that." (c6).

Similarly, another man found that a "chat" with the staff could reduce his sense of isolation.

> ".... when someone's on drugs they become very very isolated. That's my personal experience. I feel very isolated. To be able to come to a place to have a cup of coffee, sit down and have a chat with someone and tell them how you feel, it makes such a big difference." (c4).

However, this man also recalled a specific intervention from a member of staff that had helped when he had been very low in mood.

> "About a year ago I was going through a dodgy part and I actually contemplated topping myself..... I come in here, get the works, to go and do it, to top myself. He [*staff member*] didn't know this. He said, what's the matter ****, you don't look very well. And I nearly burst out crying..... He had lots of things to do but he made time to sit and talk with me. We talked for about an hour, I walked out and I didn't feel isolated any more and I didn't want to kill myself. I'm not one of these easy people that easily come up and say, oh yeah I wanna kill myself..... So if it wouldn't be for this place, I think I might have been dead." (c4).

This interaction provided containment at a time of acute distress. Although "therapeutic" in an obvious sense, the participants' accounts of their relationships with staff suggest that these interactions are containing because they derive from interactions defined in terms of normal communication and "chats", rather than explicit counsellor / client relationships.

These interactions can be seen as providing the emotional aspect of social support described by Orford (1992). However, there is also a sense of companionship support in these interactions which may also be facilitated by the minimisation of professional difference and flexibility of boundaries described in Section 7.3.2. The value of this support in relation to safer drug using

behaviour is explored in Chapter eight. A final function of the interactions between staff and clients is outlined below.

7.4.6 The service as a source of support when drug free

Two participants had used the service as a source of support when drug free. This was an interesting finding since the service, as a needle exchange, was not designed to provide this support. One man described an interaction he had with a member of staff:

> "I've just come in to say how're you doing, I'm not using, I've just come to say hello, I was just passing by, and we sat down and had a chat and had a coffee and that and just the fact that she was prepared to talk to me anyway - Some people would say, oh, if you're not using .... you don't need to be here, there's other people that need the service. And there's that kind of cold clinical effect of a place that makes you think, well fuck this, and sends you out the door in a bad frame of mind." (c6).

The low threshold access to a supportive relationship was deemed important in addition to his drug free status not precluding him from this interaction. That time was given to him appears to have been important in enabling him to maintain a drug free state.

> "It's just nice to have someone tell you that you're doing well because you don't always get that... to hear that from somebody who's seen you at your worst by coming in here really, and then see you straight and say, you're doing really good, it's good to see you straight. That is a boost, and it's a boost that gets you through that day without using." (c6).

It is unusual that a service based around providing injecting equipment would be used in this way. However, considering the quality of the staff / client relationships outlined and the value ascribed to these, then using the service for support when drug free is understandable. The working approach of the staff in the service facilitated open communication and the formation of supportive relationships that were utilised in various stages of drug using behaviour. In the final section of this chapter, the potential for developing aspects of the working approach in a more formal way is considered.

7.5 Developing a theory to the working practice

The interactions described can be usefully viewed in terms of enhancing elements of motivation and providing functional support. Different aspects of the staffs' working approach can also be seen as motivational interviewing strategies. This could be seen as creating the conditions in which behaviour change, in terms of safer drug use, may be discussed, facilitated and maintained. However, the use of motivational interviewing as a theory of intervention was not explicitly stated by staff. This raises the question of whether they could be more active in enabling clients to change. This study argues that their mode of intervention is based on an intuitive idea that clients benefit from interactions which are qualitatively different from others they may experience. Having an explicit theory may be a useful starting point to thinking further about their working approach and developing interventions that enable clients to make changes in their behaviour. Bilsen's (1991) motivational milieu therapy could be particularly suited to work in this service. Interventions are planned by staff based around these ideas of motivation, which are then implemented and evaluated using behavioural principles. This idea of developing a more explicit theory to the working approach is considered further in Chapter nine.

7.6 Conclusions: Interactions between clients and staff

This chapter has outlined themes that emerged from clients' perceptions of their interactions with staff. These include perceiving the staff as similar to themselves, feeling accepted and having special relationships with staff. Their interactions with staff were defined in terms of normal communications and not as typical professional / client interactions. The functions of these perceptions are discussed as strategies for engagement, providing various aspects of support and enabling the building of self- esteem. The staffs' perceptions of their working approach is also outlined. It can be described as maintaining a positive approach towards the clients, being accepting of their behaviour, offering care and support and working sensitively with their professional boundaries. Much of this occurred in the context of normal communication. The functions of this approach are similar to those outlined in relation to the clients' perceptions and can be usefully thought of in terms of theoretical ideas in the motivational interviewing and social

support literature. This also suggests ways in which the quality of the interactions occurring within the service may be related to safer drug use and behaviour change.

The following and final analysis chapter refers to the level of self. It develops the ideas discussed in this chapter regarding self-image and esteem.

Chapter 8 Analysis: The self

8.1 Introduction

The fourth and final level of analysis is that of self and it refers to individual behaviour. The literature on needle exchange indicates that changing individuals' drug using behaviour is the primary focus of this intervention. This is manifest in the simplistic health behaviour models put forward to explain how needle exchange functions to achieve this aim (Stimson, 1989). However, I suggest that these theories do not provide sufficient depth to thinking about the variety of processes and interactions that may occur in the context of needle exchange or how these aspects of services may be significant in safer drug using behaviour. Therefore this study considers a service, how people utilise it and their drug using behaviour within a psychosocial context. This gives a rationale for the methodology used as a means to draw out connections between peoples' drug using behaviour and the influence of material and social structures, rather than viewing it simply as a consequence of their individual psychology.

In this chapter, analysis is aimed at the level of self: it draws upon the findings reported in previous chapters and considers the implications of these ideas as they are manifest at this level. It is concerned most directly with psychological processes, in particular, constructs such as mood states, self-image and self-esteem and also how these relate to safer drug use. It also considers the extent to which the service may be significant in influencing and/or mediating the consequences of these psychological states and its potential for influencing safer use of drugs.

This chapter begins by detailing the participants' explanations for sharing with reference to psychological health behaviour change models. Secondly, a model is proposed as a way of thinking about sharing behaviour in terms of psychological processes. This draws on participants' accounts of their behaviour and self-identity, using ideas from cognitive models of substance use as a framework to understand how the themes identified may relate to injecting risk behaviour. Aspects of this model are used to consider how the interactions (and therefore the service) described in the previous chapter may be significant in reducing drug related harm.

8.2 Explanations for sharing and knowledge about safer drug use

No participants stated that they regularly shared injecting equipment. Those who reported that it had occurred indicated that it had been prior to contact with the service and due to exceptional circumstances related to being in withdrawal and as a consequence of non-availability of injecting equipment. The following quote illustrates these two points:

> "Yeah I did care about me health before but I couldn't get hold of them [*injecting equipment*]. And as I said, if I'm a junkie and I'm sick [*in withdrawal*] I will use someone else's or I'll use an old works." (c4).

This quote raises points to consider in relation to psychological models of health behaviour. Caring about health illustrates knowledge about the risks of sharing, yet despite this, sharing could still occur. This is an example of how knowledge about the risks of sharing is not always translated into a "rational" health related behaviour. Most of the psychological models of health behaviour reviewed include a knowledge component and assume it to be central to the occurrence of the related behaviour (Becker, 1974; Fishbein and Azjen, 1975; Catania et al., 1990). Yet research has indicated that knowledge about risks does not predict unsafe injecting behaviour (Klee et al., 1990). In terms of motivation, defined by Miller and Rollnick (1991) as competing contingencies, the man quoted above states that non-availability, withdrawing from drugs and being a "junkie", all mediate the occurrence of safer injecting, despite knowledge about the risks of sharing. These competing contingencies to beliefs about the importance of safer injecting are considered below.

Non-availability of injecting equipment, outlined in Chapter four, is an obvious constraint on using drugs safely. This could be seen as a "perception of barriers to treatment", an element of the health belief model (Becker 1974), although non-availability may be a reality rather than simply a perception. But how non-availability is acted upon varies between individuals. For example, one man said:

> "I know some people that'll do anything [*implying sharing injecting equipment*] yet again I know some people that'd end up drinking it [*the methadone ampoule*]". (c6).

For some people, sharing may be more likely to occur when in drug withdrawal, suggesting that the behavioural probability that safer drug use will occur also varies within individuals. Opiate withdrawal is characterised by various physiological symptoms that also have psychological correlates which can be described in terms of arousal. The meaning of the experience of these mood states is also mediated to some extent by an individual's cognitions. These may influence the extent to which alleviating this state supersedes other concerns, such as the (potential and long-term) consequences of sharing injecting equipment. The explanation of sharing, because "I'm a junkie", suggests another set of mediating cognitions and can be understood in terms of self image.

The following sections consider these two mediating variables to safer injecting: mood states and self image. To think about how the service may function to change these and therefore potentially impact on drug using behaviour, a psychological model of sharing behaviour is initially outlined.

8.3 A proposed psychological model of sharing behaviour

Four of the clients interviewed implied that they had underlying problems of which drug use was symptomatic. This was mentioned in relation to pharmacies not being able to offer support (Chapter six) and the value of support received through interactions with staff (Chapter seven). Two participants said:

> "People like us have got problems."
> "We're not the most stable." (c1/2).

As indicated in Chapters four to six, participants felt excluded from support structures because of their drug use. This left them vulnerable to feelings of isolation. One client noted the physical addiction, the daily need to use and the consequent illegal activity, all of which made him feel isolated.

> "Drugs make you feel isolated.... your body needs to have them so the majority of the time you're either running about trying to get them and then once you've got them you use them. And then in the morning you wake up sick and you've got to go out, you've got to go stealing from shops and whatever in order to get your money." (c4).

The consequences of having "problems" and feeling "isolated" for drug using behaviour are likely to be complex. Although this study does not explicitly attempt to find a causal relationship between these statements and safer drug use, some of the research outlined in chapter one suggests possible connections. To place these ideas in a theoretical framework, a cognitive developmental model of substance use forms the basis to a proposed psychological model of sharing behaviour described below.

Liese and Franz (1996) describe a cognitive developmental model of substance use in which beliefs about the function of drugs are central to the development of problematic use. Beliefs about what drugs do become important mediating factors to core beliefs which centre around lovability and adequacy. Toneatto (1999) describes these as metacognitions, beliefs about the effect of substance use on cognition. Substance use serves the function of, and is negatively reinforced by, changing the aversive mood states that are a consequence of the core beliefs. In Chapter one, some of the literature reviewed on sharing behaviour indicates that sharing is associated with aversive early experiences, such as being sexually abused and low mood (Strathdee et al., 1997). Strathdee et al. hypothesise that low self-esteem is a consequence of these experiences and/or mood states and this may be related to risk behaviour although they do not develop this idea further. I suggest that the cognitive developmental model described, in which drug use becomes habitual as a consequence of the functions it serves, offers a useful way to think about how low self-esteem may relate to injecting risk behaviour. This is described below.

A low sense of self-esteem is likely to be both a cause and consequence of low mood and could give rise to a set of cognitions which could be described as a sense of powerlessness, or low self-efficacy (Orford 1992). Low self-efficacy might result in reduced perceived control over events, including engaging in the necessary behaviours to acquire injecting equipment. This experience may in itself be aversive, reinforcing the sense of powerlessness and increasing the salience of the metacognitions and beliefs about the functions of using drugs.

To link this model to drug using behaviour, I refer the reader to Miller and Rollnick's (1991)

definition of motivation outlined in Chapter one, that is, motivation as a consequence of competing contingencies. Beliefs about the function of drug use and self-esteem can be seen as competing contingencies to beliefs about using drugs safely. The salience of these beliefs may vary within the individual over time as a consequence of other factors. For example, when in withdrawal the strength of the beliefs about what using drugs will do, and the extent to which the mood states are perceived as aversive, may increase. In the context of poor availability of injecting equipment and a sense of powerlessness about engaging in safer drug use, alleviating the negative mood and physiological states could supersede the motivation to engage in behaviours to fulfil beliefs about the need to inject safely.

This model is proposed as a way in which to think about how sharing injecting equipment may be mediated by psychological factors and should not be considered as separate from issues discussed in the previous chapters. For example, the service clearly provides low threshold access to injecting equipment, close to the point of drug purchase (see Chapter three). In terms of maintaining safer drug use in the context of negative mood states and beliefs about the function of drug use, low threshold access to injecting equipment is potentially vital. A staff member suggested that people would be less inclined to share

> "if it's easy to get hold of them [*injecting equipment*], because it's very much, I want it, I want drugs now." (s3).

People may not need to have strong beliefs about safer drug use to use them safely if there is good availability of injecting equipment. Similarly, low self-esteem, may be influenced by positive interactions with staff (Chapter 7). This may also mediate the discomfort of mood states and salience of metacognitions regarding the function of drug use. The role of the service in containing negative mood states and enabling a positive self image are described below.

8.4 Crisis support and low mood

"Sometimes I've come in here, I've just wanted to do myself in. I've not really been suicidal, I wouldn't say I'd do myself in but I wouldn't give a shit if I dropped dead really, 'cos you know you can get that low. When you're living on the street and you've got no money and you're strung out and everything's caving in on you,

> walking through that door is sometimes that little ray of sunshine that stops you going over the edge." (c6).

This quote, and the ideas presented in Chapter seven, highlight the role of the service in containing negative mood states. While this participant's mental state was not explicitly linked to unsafe drug use, in terms of the model outlined above, it could be argued that at these times, in particular contexts, people may be at a high risk of sharing. The man quoted above indicates a sense of futility and sense of hopelessness about himself and his life which is indicative of low mood and low self-esteem. Through interacting and receiving support from staff, this mood state had been alleviated. Another man said:

> ".... it's uncaring out there.... but I come in here and it's almost like a little shelter, like a watering hole - for emotions." (c4).

This could be understood in terms of the direct effect model of stress alleviation (Stowe et al. 1993). The service has the potential to reduce stress directly through supportive interactions and raising self-esteem. This in turn may help maintain safer injecting, through the alleviation of aversive psychological states, which in the context of poor availability of equipment, could become competing contingencies to beliefs about using drugs safely. In the next section the role of the service in relation to self identity is considered.

8.4.1 Self image and safer drug use: Junkie vs. drug user

One of the key themes that emerged from the interviews with clients was the junkie versus drug user dichotomy particularly in relation to self identity and the behaviours and perception of other drug users. The dichotomy was invoked in a number of different ways as outlined in the table below.

Table 8.1: The junkie / drug user dichotomy

Junkies	Drug users
Have no self respect.	Have self respect.
Share injecting equipment.	Use drugs safely.
Are not concerned about the public; inject indiscreetly, do not dispose of injecting equipment safely and do not clear up after injecting in public spaces.	Are discreet and socially responsible in their drug using practices.
Use drugs chaotically.	Are stable in their drug use.
Have problems.	Are normal apart from drug use.
Are marginalised from support structures.	Are integrated in society.
Are only concerned about and able to talk about drugs.	Are able to interact with others about non-drug related issues.
Are "scum", amoral, untrustworthy, violent and rob other drug users.	Operate according to some form of moral code.
Are not like the staff.	Are similar to the staff.

The term "junkie" was therefore negative and often used in relation to perceptions of other service users. Interestingly, it was used by one participant to describe himself in the context of, and as an explanation for, sharing injecting equipment. This indicates how the perception of self in relation to these ideas is not static.

Most apparent was the self referential use of the term "drug user" by participants as a way to distance themselves from other service users and as a way to define themselves as similar to the staff (Chapter five). This dichotomy appeared to be central to people's self identity and was particularly manifest around the theme of "normal" communication (Chapter seven). The ability

to chat normally with staff was a way to distance a sense of self from that of "junkie" and can be understood as serving the function of raising self-esteem. In terms of self regulation theory (Miller 1998), if a positive sense of self-esteem is a consequence of being a drug user and associated with using drugs safely, unsafe use would create dissonance. This suggests a process by which safer drug use might be maintained and may be a significant element of Bilsen's (1991) model of motivation, as it refers to a sense of concern about the consequences of a particular behaviour. This concern is also an aspect of some of the psychological health behaviour models outlined in Chapter one. In this sense "drug user" could be conceptualised as a positive motivational construct that enables the maintenance of safer drug use. As one man stated, how people perceive themselves while using drugs will impact on their using behaviour and likely experience of health problems.

> ".... how we turn out after we've gone through our drug use state is how we regard ourselves during the period of using. You come out for better or for worse." (c6).

8.4.2 Contact with the service and self image

In relation to the model described in Section 8.3, using drugs safely, facilitated through improved access to injecting equipment, may in itself be esteem building. This occurs through countering a sense of powerlessness about behavioural change and thereby, increasing a sense of self-efficacy about using drugs safely. In terms of Bilsen's (1991) theory of motivation, increasing a sense of competency about changing behaviour is part of the process of changing that behaviour. This is based on Bandura's (1977) idea of self-efficacy. However, I would suggest in relation to the findings of this study that it is improved availability of injecting equipment that increases the probability that safer injecting occurs, which in turn increases a sense of competency about engaging in this behaviour. In other words, the behavioural event of using clean injecting equipment precedes the cognitive changes about feeling able to engage in this behaviour. I base this assertion on participants' accounts of difficulties in accessing injecting equipment prior to engaging with the service studied (see Chapter three). This indicates the importance of addressing environmental barriers to engaging in health related behaviours as a precursor to facilitating changes in individuals' beliefs. In the context of improved availability, maintaining safer drug use

and a sense of competency about this is also likely to be reinforced through the perception of self as drug user.

A second way in which the service may impact on self-image is manifest in the value clients attached to interacting with staff; this enabled the positive perception of self as "drug user". This suggests that the quality of the interactions between clients and staff may be indirectly significant in maintaining safer drug use. This could be understood in relation to a positive sense of self-esteem and the buffering model of social support (Stowe et al., 1993). The interactions, through maintaining a positive sense of self-esteem, reduce the impact of stressful events or reduce the perception that these events are stressful, which may be protective in terms of psychological distress, a potential risk factor in unsafe drug use. The value of the clients interactions with staff, in maintaining a positive self image and mediating the experience of stress, is important to consider in relation to the marginalisation from support structures and the negative interactions within the network described in Chapters four and five. This marginalisation is likely to be partly a consequence of the powerful contextual discourses that stigmatise and criminalise drug users discussed in Chapter five. The concept of "junkie" is clearly a socially constructed manifestation of these discourses. The concept of "drug user", on the other hand, is an attempt to redefine a set of behavioural practices in a way that avoids this social stigma. In this sense it should be encouraged as part of a process of self empowerment which, through increasing a positive self perception, may increase the likelihood of safer injecting. This idea is developed in the next section.

8.4.3 Self perception: changing and maintaining safer drug use

Chapter one outlines the study by Prochaska et al. (1992) which highlights psychological processes that are associated with behaviour change and places these in the context of their transtheoretical stages of change model. This model can be most usefully understood as describing how people change behaviour, rather than as an explanatory theory of how change occurs. These processes can also be considered in relation to Miller and Rollnick's (1991) motivation enhancing strategies and Orford's (1992) description of the functions of social

support. In terms of self-image, various processes of self-evaluation are associated with a move towards changing behaviour. As indicated in Section 8.4.1, there is a problem in determining the causal relationship between cognitive processes and related behaviour. However, there is still value in thinking about the findings of Prochaska et al. (1992) in relation to the quality of the interactions between clients and staff as described in Chapter seven and the connection with self-identity.

At the pre-contemplation stage, consciousness raising, discussing the issue and evaluating the impact of the behaviour, are all associated with a move towards contemplating doing something about the behaviour. Various aspects of the interactions between clients and staff can be seen as fulfilling these functions. At the contemplation stage, a further process of self evaluation occurs which is associated with doing something about the behaviour. Forming a self perception of drug user as opposed to junkie may be part of this process. In the action stage, a concept similar to self efficacy is invoked and again this relates to self-image and the belief in the ability to change. Identification with the staff, by perceiving them as ex-users, may be an indication of this particular process. Finally, maintaining a behavioural change is associated with behaviours rather than cognitions. It can be described in terms of moving away from environmental aspects associated with problematic behaviour and finding alternative reinforcing activities. In relation to this study, the negative view of others and disengagement with the network of drug users may be indicators of this process occurring and be part of maintaining safer drug use and a dissociation with junkie behaviours.

Prochaska et al. (1992) term one process associated with maintaining change as "social liberation". This can be seen as a form of social action and, as in Holland's (1992) work, involves the person who had been experiencing a difficulty actively working to reduce the occurrence of that problem in their community. In Holland's work this was part of the process of shifting the focus and cause of the problem from the individual to the wider social context and campaigning to change the contexts that contribute to the individual's initial experience of difficulties. In relation to this study, and in terms of interventions to increase the behavioural probability that safer drug use may occur, this may be why two of the participants became involved in secondary

distribution of injecting equipment. Not only is it an expression of concern for their peers but it is part of maintaining safer drug use themselves. These ideas are developed in Chapter nine.

8.5 Conclusions: The self

This study suggests that contact with the service may have had a positive impact on clients' self image and this may be related to self-esteem and the construct of "drug user" as defined in contrast to "junkie". The service also has the potential to impact on negative mood states thus fulfilling an important supportive function. In terms of a proposed psychological model of sharing behaviour, the quality and function of the interactions with staff have the potential for mediating negative beliefs and mood which may then be significant in helping people to use drugs in safer ways.

Chapter 9 Conclusions: Interconnections, reflections and recommendations for service delivery

9.1 Introduction

This concluding chapter is divided into three sections. First, connections between the four levels of analysis in the research map are considered. This draws together the major findings and ideas of this research, providing an overview of the ways in which the service studied may impact on drug using behaviour. Essentially this places the service, the interactions within it and the clients' drug using behaviour within a psychosocial context. This gives more meaning to the findings by highlighting how issues identified at different levels are mutually constituted and reinforcing. Implications that can be inferred from the ideas highlighted by this research are outlined in order to think more generally about services for drug users and injecting risk behaviour. Secondly, a critical reflection of the study is undertaken. This is an essential stage of the methodology and it consider issues of validity and ideas for future research. Finally, based on the findings from this study, general recommendations for the delivery of services for drug users are made, followed by some recommendations specific to the service studied.

9.2 Interconnections

The choice of methodology and use of the research map were a consequence of wishing to develop an in-depth understanding of how a needle exchange service may impact on drug using behaviour. This included an exploration of the meaning and quality of interactions within the service and not simply a focus on individuals and their drug using behaviour. It also involved considering the findings both in relation to the setting in which the service existed and the wider context. The interconnections between these different perspectives are outlined below.

9.2.1 The context

The service exists as a consequence of and also in relation to laws, policies and discourses about

drug use and the people who use them. These can be understood in terms of discourses which shape the thoughts and actions of the staff and clients within the service. In relation to injecting drug users, some discourses contribute towards to social exclusion: for example those that are institutionalised within laws and policies that aim to control drug use through criminalisation. Other discourses could be described as socially inclusive such as those surrounding harm reduction policies. These two strands of policy / discourse, while being understood as contextual within the research framework used, have consequences manifest at other levels.

The clients interviewed were marginalised from support structures, including drug treatment agencies, family and friends. This can be thought of as a form of social exclusion, maintained through the social stigma attached to injecting drug use and involvement in deviant subcultures (McDermott, 1992). Marginalisation from support structures is also likely to reduce access to material resources, creating economic deprivation and difficulties, such as housing problems which are also associated with injecting risk behaviour (Stimson, 1992a; Donoghoe et al., 1992b).

The consequences of this exclusion are also manifest at a psychological level. This could be described as a sense of powerlessness, decreased self-efficacy, poor self -image, low self-esteem and a vulnerability to psychological problems, such as the experience of low mood. These may also be considered as risk indicators of developing problematic substance use and injecting risk behaviour (Liese and Franz, 1996; Strathdee et al., 1997).

To understand this relationship between context and individual behaviour, Smail's (1990) model is referred to. This describes the ways in which distal influences (culture, class and ideology) and proximal influences (family, relationships and work situations) influence people and their behaviour. His model highlights the importance of understanding an individual within a social context and draws out social and psychological interconnections.

I argue that the service studied functions to counter some of the effects of social exclusion. I suggest that this can be thought about as processes of social inclusion that operate at a number of

levels. First, the service provides injecting equipment and exists as a contact point for people who have minimal contact with other services. It therefore provides a potential way out of a drug using world (Donoghoe et al., 1992a). The interactions that clients have with staff also fulfil some social support functions (Orford, 1992). These may be significant in alleviating psychological difficulties that mediate the motivation to engage in safer injecting behaviour and can be understood in terms of models of support and stress reduction / protection (Stowe et al.,1993). This, I suggest, is particularly important in helping people maintain safer injecting practices.

9.2.2 The setting

A consequence of social policies that criminalise drug use is the creation of illegal drug markets. This study demonstrates that the service had a complex relationship to a drug market. This was important in terms of maintaining and developing a client base and through facilitating legal access to injecting equipment for people who used the illegal market.

The existence of the market is evidence of a social network of drug users. However, I suggest that the illegality and specific structure of this market impacts negatively on the quality of the relationships among drug users within this network. In particular, it leaves people vulnerable to violence and exploitation from others (see also Edmunds et al., 1996). This contributes to the negative perception of other drug users within the network and has implications for the development of peer norms about safer injecting and interventions at this level. Although some consensus existed concerning anti-social behaviour, and there was evidence of the network censuring these behaviours, the network was not defined in terms of supportive relationships. This meant that the service had an important role in relation to the market.

The service provided a relatively safe space for drug users to be and to interact. This was because the staff excluded some behaviours associated with difficulties in interactions between clients in the market. This refers to one way in which I use the term "transitional". That is, the service provides a space within which people can be open about drug use without it precluding their access to support, but they can also experience interactions that do not have anything to do with

drugs. In this way it was a culturally appropriate space, existing as a bridge from a drug using culture to one based on more normal social rules and interactions. This is another way in which the service could be described as inclusive and potentially important at a psychological level.

9.2.3 Situated activities and self

A major focus of this study was on perceptions of interactions between staff and clients within the service. As stated above, these relationships can be seen as fulfilling a number supportive functions (Orford 1992). I argue that the quality and function of these interactions have psychological consequences related to enabling a positive self-image, raising self-esteem and mediating negative mood states. More specifically, these interactions facilitate a positive reconceptualisation of self as "drug user" as opposed to "junkie". This perception of self and a positive sense of self- esteem and mood to which it relates are potential mediating factors related to safer injecting (Strathdee et al., 1997). The relationship between clients and staff is one of the most important ways in which the service was inclusive, and can be most clearly seen in relation to the idea of "normal" communication.

Within this idea of "normal" communication, processes associated with changing and maintaining behaviour were also apparent (Prochaska et al., 1992). In the context of minimal use of other support networks, the service as a flexible, low threshold contact point for relationships that facilitate these processes is likely to be important. This may explain why two of the participants had used the service for support when drug free.

In relation to the interconnections between social interactions, self and behaviour change, some of the theory underlying motivational interviewing is useful to consider (Miller & Rollnick, 1991), in particular, the emphasis on the quality of social interactions, which is congruent with the staffs' working approach. In terms of these ideas, the relationship can be seen as an important vehicle for behaviour change, increasing the salience of interventions around injecting behaviour. At the level of self, and in terms of a transitional space, the service facilitates the expression of ambivalence about drug use and using which, in the context of supportive esteem building

relationships, may facilitate safer drug use.

The core function of the service, the provision of injecting equipment, is interesting to consider as a final illustration of the interconnections between the findings across the levels of the research map. The service and the legal supply of injecting equipment are consequences of inclusive harm reduction social policies. Drug users' access to this injecting equipment is facilitated both by the position of the service in relation to a drug market and the working approach of the staff in the project. Good access to injecting equipment enables a sense of competency about being able to use drugs in safer ways which may impact on self image and identity; seeing the self as a "drug user".

These processes highlight how the service may facilitate and help maintain safer drug injecting behaviour among its clientele. In the following section some general implications of the research are considered.

9.2.4 Summary: Key findings, theoretical perspectives and the use of the framework

The findings from this study suggest a number of ways in which the service studied may impact on the drug using behaviour of its clientele. The findings add to existing theoretical perspectives on the importance of social support in relation to practical help, self image and self esteem for injecting drug users in relation to injecting risk behaviour.

The utility of the framework is that it enables individual behaviour to be understood in a psychosocial context. In particular it illustrates how maintaining a positive sense of self esteem, and therefore possibly safer drug use, is constrained by discourses surrounding injecting drug use. This leads to marginalisation from support structures, influences the quality of interactions within a specific drug dealing network and helps explain the significance of the interactions occurring between the staff and clients in the service studied. The framework enables both theoretical perspectives and research findings to be located

across different levels of explanation. This facilitates theoretical interconnections, gives greater depth to the findings presented and contributes to debates within community psychology which seek to understand how social settings and interactions impact on individuals' and their behaviour.

9.2.5 General implications of this research

Although this study concerns a specific service, some of the findings and theoretical ideas presented have a general relevance for thinking about injecting risk behaviour and interventions to change this behaviour. These are: the relationship between the working approach of staff and the quality and functions of the relationships this facilitated, the service as part of a drug using network and the conceptualisation of sharing injecting equipment as a multiply determined phenomenon.

9.2.5.1 The working approach

This research demonstrates the importance of reflecting on the working approach of staff in services for drug users. Maintaining an accepting and non-judgmental approach to clients is likely to facilitate their engagement and use of the service, as well as the salience of interventions / treatment. In contrast, an approach based around coercion and overt manifestations of professional power could be seen as creating barriers to accessing services, as well as potential interpersonal difficulties between staff and clients within these settings. In relation to the service studied, the working approach was facilitated by the absence of substitute prescribing. However, I suggest that all services for drug users, including those that prescribe, could benefit from a working approach that is more client-centred. Much of this can be developed by embracing motivational interviewing as a basic philosophy of treatment. I refer specifically to Rollnick and Miller's (1995) paper in which motivational interviewing is described in terms of a "spirit" as opposed to a set of techniques. Taking on these ideas may be a challenge to some service cultures, necessitating client involvement, staff training and a critical reflective approach to their practice, but ultimately it may be rewarding in terms of enabling drug users to change their

behaviour.

9.2.5.2 Services for drug users and drug using networks

This research highlights how the service has a close relationship with a specific drug using network. Other services may not have such a clear relationship, nevertheless the fact that drug users use and interact within them means that all services are likely to be part of drug using networks. The extent to which a service may be in a position to influence behaviours and norms within a network is debatable. However, recognising that there is a potential relationship between drug services and drug using networks is the first step to thinking more creatively about interventions. Using knowledge of the quality of the interactions and behaviours within a network and reflecting on ways to encourage clients to interact with each other and spend time in non-drug related activities may be useful processes and lead to important interventions.

9.2.5.3 Sharing injecting equipment as a multiply determined phenomenon

The literature reviewed in Chapter one and the findings of this research indicate the complexity of processes involved in sharing injecting equipment. Theories from different levels of explanation all contribute to an understanding of the behaviour. The concept of motivation is introduced in this study as a way of thinking about the range of processes as competing contingencies. Motivation, therefore, is a useful integrative concept. The value of this idea is that a broad theoretical understanding of sharing behaviour can be maintained. Moreover, it highlights how no single theory or intervention will fully explain or be completely successful in reducing the occurrence of sharing injecting equipment.

9.3 Critical reflection and limitations of the research

This section considers five issues: my role as the researcher, the sample characteristics, the historical context, setting of the study, and the process of data analysis. The ideas presented in this section are part of the reflexive research process and considering what Stiles (1993) calls the

"trustworthiness" of the research. Reliability refers to the trustworthiness of the data and validity the trustworthiness of interpretations.

Reliability in qualitative research concerns more than the extent to which observations are repeatable (objectivity). Instead Stiles (1993) refers to a concept of "permeability"; the extent to which interpretations and theories are changed through interaction with the data. Good practice in qualitative research aims to enhance permeability by making explicit the researchers orientation and social and cultural position, the circumstances under which the data were gathered and the process of data analysis. These issues have been raised in Chapter 2 and summarised in figure 2.1. The use of the map (figure 2.2) also describes the researcher's theoretical position. Issues of reliability are considered in the following sections in relation to the role of the researcher, sample characteristics and the time of the study.

There are also a number of ways to reflect on the validity of interpretations in qualitative research. Stiles (1993) has produced a useful typology of validity issues which refer to the impact of the interpretation (on the reader, researcher, participant) and the type of impact (fit or growth in understanding). These are considered in relation to the process of data analysis.

9.3.1 The role of researcher

As both a member of staff in the service studied and a researcher, it is crucial to reflect on my role in relation to this study (see Figure 2.1). This has implications for the reliability of the data and validity of the interpretations made in this study. I believe that, despite my part-time status, I was identified by clients as a staff member of the service. Consequently it is important to reflect on possible processes occurring during the interviews and the impact this may have had on the data.

To some extent the client participants who agreed to take part were self selected and it is possible that they were seeking approval in the context of the interview, including presenting the self as a good drug user and as a responsible and appreciative client. It is also possible that my status as a white, male, middle-class professional may have contributed to this process. Yet it is also evident

that those interviewed disclosed revealing and personal information. This has led me to consider whether some of the processes occurring between clients and staff and the functions of the interactions described in Chapter seven, were also occurring in the research interview, in particular, using the interaction as a means of maintaining self-esteem and a positive self-image. However, if those who agreed to be interviewed were gaining these things from the process, it could be argued that my identification as a staff member added to rather than detracted from the validity of the data; because the processes occurring in the research interview reinforce the findings of the study regarding the interactions between staff and clients within the service. I suggest that it is difficult for the relationship between researcher and participant not to reflect the interactions the research is seeking to understand. What is important, however, is using my position as an "insider" in relation to the research to enable me to see and reflect on these processes occurring.

Perhaps similar issues need to be considered in relation to the staff interviews. A process of approval seeking and presenting as a good reflective member of staff to "the clinical psychologist" could have been occurring. My approach to the interviews was an attempt to minimise this possibility. This could be described as collaborative, that is, seeking to describe and explore ideas about working practices with the staff, rather than as an expert uninvolved with the setting except in a research capacity. This objective stance would have been impossible given my role in the service and, being an "insider", it assisted an in-depth discussion of the relevant issues. The congruence between the way the staff described their approach and the ways that clients experienced their interactions with staff also suggests that a reasonably accurate account of their working approach was given.

It is questionable how the issues which this research sought to explore could occur without the researcher impacting on the generation of data. I was not anonymous within the service and reflecting on possible processes occurring in the context of the interviews is part of considering the validity of the arguments presented in this study.

9.3.2 Sample

Some of the clients' motives for taking part in the study have been discussed in the preceding section. In this section, I consider the extent to which the client sample could be considered representative of the service users and how differences between the clients may have impacted on the validity of the arguments presented and process of data analysis.

First, all the clients were white British, which is representative of the clientele. However, a strength of the methodology chosen for this research is that enables difference to be explored. As access to drug services by people from different ethnic groups is poor it may have added to the data if clients who did not identify themselves as white British had been interviewed. Unfortunately this was not possible.

Another sample issue is that longer-term service users may have been over-represented. Certainly differences emerged between those with a longer history of contact and the younger man (c5) who had only recently accessed the service. The difference between this man and the other participants indicates a process of engagement with the service which may be interesting to explore in future research.

Seeking to interview a more recent client was an attempt to avoid what Miles and Huberman (1994) call "holistic fallacy". Client 5 was actively selected because he was not known to the staff and to introduce a potentially different perspective into the data set. Although he had a choice not to be interviewed, his selection was an attempt to avoid interviewing just longer-term clients who may have been more likely to agree to take part (self selected); possibly also those who would be more positive about the service. Attempting to avoid holistic fallacy in interpreting the data was also why staff and client perspectives are presented together in the preceding chapters in order to present a range of perspectives on the issues discussed (triangulation).

Although clients with a longer history of contact with the service may be expected to be more reflective about the issues this study sought to explore, there was also a sense that they may have

been more reflective about aspects related to their drug use generally. Their comments about themselves and other drug users, the impact of their drug use on their relationships and identification with the staff may all be seen in this way. It is possible that clients use the service in different ways depending on their "stage" of drug use; one of the longer-term clients (c4) was seeking a period of respite from using at the time of the interview. This was very different from client 5 who had not engaged with the staff and utilised the service primarily as a place to buy drugs. The differences between clients use of the service could have been explored further with a larger sample size and understanding this difference in relation to ambivalence about drug use could form the basis to a future research project.

Expressions of ambivalence about drug use may be an indication of another process occurring in the context of the interview (Miller and Rollnick, 1991). Many of the questions required clients to reflect on their drug using lives and it is possible that the interview itself may have been part of a dynamic change process. It would not be surprising therefore that ambivalence about various aspects of drug use were interpreted from the data. However, rather than detracting from the validity of the data it is possible that facilitating expressions of ambivalence highlights another way in which the service is used, particularly by long term clients. It is perhaps paradoxical that the service can simultaneously encourage the expression of ambivalence about using drugs while facilitating the use of drugs through the provision of injecting equipment.

Another issue to consider in terms of the analysis is what Miles and Huberman (1994) term "elite bias". This can occur when more articulate participants become over represented in the analysis. This is difficult to avoid. Two clients in particular (c3 and 6), were more erudite and expressive of their opinions. Although, their comments may be more represented in the preceding chapters, the same iterative process of data analysis was applied to each of the transcripts to draw out difference and diversity in opinion.

Finally, some of the questions asked of participants were designed to set a context to the interactions within the service, particularly in relation to social support. It is acknowledged that clients support systems were not evaluated in great depth, largely due to time constraints. A more

sophisticated analysis of social support structures could form the basis to a future project.

9.3.3 Historical context of the study

An issue mentioned in Section A of this thesis was the difficulties being faced by the service in terms of public pressure to close it down. The potential for this to happen was one of the reasons for wanting to research the area. In relation to the focus of the study, client awareness of these issues may have had some bearing on their accounts of the service and their perceptions of other clients.

It is possible that they exaggerated the value of the service because they perceived it to be under threat. However, it could equally be argued that this situation assisted the study by making participants more reflective of the ways they used it. They may also have attributed the threat of service closure to the behaviour of others adding to my interpretation of the network as generally unsupportive. However, it also raises an interesting point to consider. Much of the public concern at the time of the study centred around the unsafe disposal of injecting equipment and reflected in media headlines:

"Stop this drug hell". Marylebone Mercury. 26.9.96

"Needle exchange puts children at risk". Camden New Journal. 20/3/97

This was also a behaviour associated with "junkies" by those clients interviewed. The congruence between the concerns of the public and the longer-term clients suggests a potential way forward in facilitating a dialogue between the two.

9.3.4 The setting of the study

All the interviews with the staff and four of the interviews with the clients took place in the service. Ideally these would have occurred in a different, neutral setting. It is difficult to know how conducting the interviews in the service may have impacted on the interview process. It may

have made some of the clients more guarded in expressions of criticism about the staff and service. However, given the problems in recruiting clients, it was unavoidable since there were few other options. The first two clients recruited were interviewed in a local cafe. However, because of the nature of the information disclosed, it subsequently seemed more appropriate to conduct interviews in the service where a certain amount of privacy could be guaranteed.

9.3.5 Data analysis

A critical reflection of the data analysis can be understood in terms of validity. With reference to the reader, Stiles (1993) suggests that one way to assess the validity of the interpretations is to consider the coherence of the arguments presented. This is similar to Henwood and Pidgeon's (1992) idea of rhetorical power as a measure of a studies validity. Another way to evaluate a study is by the extent to which it changes the readers perception (Stiles, 1993), which Henwood and Pigeon (1992) term "generativity". A third critical view is in terms of reflexive validity, drawing out the dialectical relationship between interpretation and observation (Stiles 1993).

Although ultimately these are issues for the reader to consider, the use of the research map was one way in which this study attempted to draw together diverse theories in relation to the area of investigation and emerging themes from the data. The final process in the analysis involved placing the themes identified within the research map. It could be argued that the research itself was focused on the level of self, and issues identified and placed at other levels within this framework are inferred from this level. The use of the map was a useful tool in exploring interconnections between levels of explanation and giving depth to the ideas presented. The complex process of locating themes in different levels facilitated this in-depth consideration of issues and I suggest that it adds to the validity of this research.

The use of the map was also congruent with my concerns as a clinician. Issues raised through contact with clients inevitably shifts into areas associated with sociology. Although this methodology facilitated a broad consideration of ideas from different disciplines, a number of areas which I did not seek to explore in any real depth were issues of race, class and gender in

relation to drug using behaviour. In recognising the limitations of this study, my hope is that these issues may be explored by others who may have a better theoretical understanding of them.

Another way of considering the validity of the interpretations is in terms of the impact on the participants involved in this study. This can be understood in terms of testimonial validity; the extent to which the interpretations make sense to the participants and catalytic validity; the extent to which it reorientates participants and enables them to know reality better (Stiles 1993). This knowledge can be useful in terms of transforming reality, a process that Holland (1992) utilises. It is acknowledged that the research as presented does not address these issues. However, discussing the ideas in this research to the staff of the project studied is planned and the recommendations outlined at the end of this chapter describe ways in which findings from this research may be applied. The potential value of involving participants more in the process of the research, for example to enable them to better understand risk behaviour, was an idea that emerged from this study, rather than one brought to the study. This is one way in which my awareness of an issue has developed through carrying out this research.

9.4 Future research

This study raises a number of ideas for future research in addition to those presented above. The following ideas are not an exhaustive list, they are presented to indicate how questions are raised at a number of levels and may be explored through the use of a range of research methods.

First, it might be useful in terms of current working practice to repeat the study in the light of changes in service provision enacted after this study took place. This may give an indication of the impact of these changes on clients' drug using behaviour.

Secondly, at a more psychological level, the way in which identity is constructed through language, particularly the use of the terms "drug user" and "junkie", and how these may relate to injecting behaviour would be interesting. A discourse analysis would be the most appropriate methodology for this type of study.

Thirdly, the study raises a number of interesting questions which could be explored from an ethnographic perspective. These include drug using behaviour within the market, particularly among those who inject in public spaces local to the service. This might be useful in thinking about peer education projects as well as addressing some of the negative publicity that needle exchange attracts. In addition to this, exploring self identity in relation to the network and other aspects of interactions within it would be useful.

Fourthly, the proposed model of risk behaviour outlined in Chapter eight could be further explored. The model might be developed through the use of qualitative methods, asking focused questions around risk and then empirically testing hypotheses using a quantitative survey based approach. Another way of exploring risk behaviour and the validity of the model would be through the use of diaries. This method has been useful in exploring the relationship between sexual risk behaviour and alcohol use among gay men, particularly refuting simple causal explanations between intoxication and sexual risk (Weatherburn 1992).

Finally, exploring the actual content of interactions between staff and clients, through observation or process note-keeping over time together with surveys of drug using behaviour would be interesting. This may enable a better understanding of the supportive quality of these relationships and the extent to which they may be indicative of processes of behaviour change occurring around drug use. Using the findings from the study by Prochaska et al. (1992) as a way to think about these processes could be useful.

9.5 Recommendations

The findings from this study have some practical utility in thinking about how a needle exchange may be able to impact on injecting risk behaviour. This final section is divided into recommendations that reflect more general issues for clinical practice, including issues to consider in relation to peer interventions and those that are more specific to the service studied.

9.5.1 General recommendations

i) Develop the concept of harm reduction. This could encompass a broad range of psychosocial interventions, including those that facilitate changes in the clients' social situation and environment, for example, helping them to access secure housing. These interventions are useful in addition to the provision of clean injecting equipment.

ii) Understand the nature of drug using networks and behaviours. Specific local knowledge is important in developing peer intervention projects. Issues to explore include: why people use the service, common issues that concern service users, the occurrence of injecting near the service, whether service users interact in different contexts, sub-groupings among service users, and whether there are people within the network who appear to be "leaders". It is important, however, not to infer a notion of community from a body of drug users. Moreover, those drug users who engage most easily with staff may not be the most suited to imparting advice to others in the network.

iii) Maintain a flexible working practice and low threshold access. Networks and needs of drug users change over time. Therefore, there is a need to maintain knowledge of the demographics of the clientele and be responsive in adapting the service to changing needs. Attention to the threshold of access in the service is important including, for example, the opening hours as well as avoiding the use of rules and regulations as the principle method of controlling the service environment.

iv) Involve clients in the service organisation. At the very least, feedback should be sought from clients about the service, but even more useful is to consider involving and working with clients in the service at a number of levels. This can be thought of as providing them with a socially valued and empowering role. Services may have the potential to exist as a venue from which a sense of community may develop. This may be enhanced through facilitating links to drug user organisations.

v) Do not underestimate the significance of everyday interactions. These may be potentially important and socially inclusive interventions. A general reflection on the working approach of the staff could be a useful way of developing a practice that might facilitate engagement of clients with the service.

9.5.2 Specific recommendations

In addition to the above points and more specific to the service studied are the following recommendations:

i) Work with the market - not against it. If clients use the service to wait for dealers, use this is an opportunity for interaction. Use the local knowledge about the market to reflect on how the service may be in a position to intervene within it.

ii) Encourage the use of the drop-in. This is a potentially important venue from which a range of innovative interventions may develop. Involve clients in running aspects of the drop-in. This may encourage responsibility and self regulation of anti-social behaviours.

iii) Foster a more supportive drug using network. Facilitate discussions about anti-social behaviours in the market. This may help to develop a consensus about these behaviours and how they may be controlled. Use this as a basis to develop peer intervention projects and consider the ways in which secondary distribution may be developed.

iv) Develop the liaison aspect of the service. Facilitate clients' use of other services.

v) Work with local pharmacists. This could enable more comprehensive access to injecting equipment and pharmacists could be encouraged to develop aspects of their role as well as know when to refer clients to the project for more active support.

vi) Work with local treatment agencies. This is important in terms of professional support and identity but also in facilitating clients' access to these services.

vii) Staff support. Acknowledge the difficulties of the work and think about the dynamics of interactions occurring within the service. Avoid either an over-identification with the clients or a punitive, dismissive approach. This requires embracing reflective practice and use of supervision.

viii) Develop a theoretical understanding of the working approach. Motivational interviewing (Miller and Rollnick, 1991) and Motivational Milieu Therapy (Bilsen, 1991) operationalise aspects of a working approach appropriate to the context of needle exchange. These ideas can be used to provide a therapeutic rationale and some means of evaluating the work. However, the cornerstone of these approaches is a humanistic client-centred style based around an accepting and humane approach to working with drug users. As this study has illustrated it may be important to be mindful that it is these basic qualities to an interaction that might be most valued and useful for clients in enabling them to maintain safer drug using practices.

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Section C

Case Study

A report of work with two crack cocaine using clients

Chapter 10 A report of work with two crack cocaine using clients

10.1 Introduction

In this chapter, work is described with two clients seeking help for their crack cocaine use from a community substance misuse service. It demonstrates the skills and knowledge of a reflexive scientist practitioner. The first four sections are descriptive. Work with two clients is described from their initial contact through to assessment, treatment planning, intervention and outcome. This illustrates a treatment approach for working with cocaine users and highlights structural aspects of the service designed to facilitate engagement. In the final sections of this chapter, the two cases presented are used to reflect on three aspects of clinical practice. First, the application of functional analysis in the assessment and intervention planning process. Secondly, the use of manuals and structured treatment interventions and how these may be reconciled with an approach based on functional analysis. Thirdly, how clinical work may be used to identify common underlying processes in the development of drug using behaviour. This can be used to reflect on the practical utility of models of substance use.

The chapter as a whole describes a reflexive process in which knowledge is applied to clinical work; this experience is then used to reflect on clinical interventions and underlying theoretical models. This chapter may be read in conjunction with Chapter eleven which critically evaluates research into the psychological treatment of cocaine use.

10.2 Service description and access to treatment

Both clients were seen within a stimulant (drug users) clinic, an element of a community drug team in a large London National Health Service addictions service. They came to be seen in the stimulant clinic through being advised by psychiatrists working in the community to attend the open access brief assessment sessions in the service. At brief assessment, people are screened to ascertain their suitability for outpatient treatment and a decision is made by the assessor, based on the primary drug problem, as to which element of the service clients are passed on to for more

detailed assessment. Within the community drug team, the stimulant clinic uniquely operates a weekly assessment afternoon staffed by a multi-disciplinary team. This enables clients to be rapidly assessed and offered treatment within one week of their attendance at brief assessment. Issues discussed in chapter eleven such as the attrition noted in the early stages of treatment and the absence of effective substitute drug prescribing, inform the belief that a rapid response to cocaine users' initial contact with the service is the best way to capitalise on their motivation and engage them in treatment.

10.2.1 The initial assessment

The Maudsley Addiction Profile (MAP), an outcome and assessment tool, is completed with clients in the early stages of treatment (Gossop, 1996). At present the stimulant clinic protocol specifies that this is completed at the first contact point. However, this is balanced with a motivational client-centred approach with the aim to maximise engagement and retain them in treatment (Rollnick and Miller, 1995). Further assessment tools are utilised as appropriate to help develop the formulation, plan and evaluate interventions.

10.3 Case 1

Case 1 is a 37-year-old white, unemployed man, living alone in a council flat.

10.3.1 Initial presentation

He is a tall casually dressed man with poor eye contact. He reported smoking crack cocaine twice weekly over the previous seven months, spending £20 to £140 weekly. He was easy to engage in assessment and stated that he used crack because of feelings invoked in psychotherapy and because his disability benefits had been reduced. He described himself as paranoid and had difficulty making friends. He said he often felt bored and lonely, had suicidal thoughts and was prone to angry verbal outbursts.

10.3.2 Background information

i) Family history

Case 1 is an only child. His father had a semi-skilled job and his mother an unskilled job. His father had a history of depressive illness, leading to one psychiatric admission when Case 1 was 17 years old. His father was also physically unwell and was experienced by Case 1 as distant during his childhood. He said he had a poor relationship with his mother, described her as domineering and uncaring and said that she had mentally, physically and sexually abused him as a child. He said he was incontinent until his early teens, when a kidney disorder was diagnosed, requiring a lengthy hospital admission. The reported sexual abuse occurred when his mother cleaned him after he had been incontinent. He lived with his parents intermittently until he was 30 years old, when they moved out of the family residence to put themselves into a retirement home. He believes that his parents moved to get away from him.

ii) Personal, educational and vocational history

Case 1 remembers little from his childhood. He reported being bullied at school due to his incontinence and he regularly truanted. He left at 16 with no qualifications. He has a patchy work record, doing numerous unskilled jobs lasting no more than three months, typically getting sacked due to arguments with colleagues.

iii) Psychosexual history

Case 1 describes himself as bisexual. He reported short-term hetero- and homosexual relationships. The homosexual relationships occurred in the context of selling sex in his twenties. He is currently in a relationship with a woman whom he met in a specialist inpatient psychotherapy unit for people with personality disorders. He said she has a diagnosis of paranoid schizophrenia. They are frequently violent to each other, usually only verbally, and often split up. He said he often feels jealous about her in relation to other men.

iv) Psychiatric history

He first had contact with a psychiatrist at 15 due to truancy. From the age of 20 he had contact with psychiatric services following deliberate overdoses and self harming behaviours, such as cutting his arms. He had a brief admission to the unit described above at 24, where he was diagnosed as having a borderline personality disorder. He self-discharged because he wanted to use drugs. From this time, he has had continuing contact with outpatient and inpatient psychiatric services. At 32, he was again admitted to the unit and stayed for six months. He was discharged for violence, while intoxicated with alcohol. Aged 35 he stopped using drugs and started a placement at a day centre. He still attends regularly and is doing a computer course. From the age of 36 he has been in psychotherapy, initially on the NHS for one year and since then, to date, privately self-funded. He is also currently under the care of a community mental health team and takes Sulperide (200 mg daily) to manage his paranoid ideation.

v) Forensic history

He has had contact with the police from the age of 15, reporting numerous offences, usually burglary and car theft. His longest period in prison was three months. He was once charged with ABH after assaulting a girlfriend and was also charged with possession of LSD at the age of 28.

vi) Drug history

He first tried cannabis at 15 and became a regular user from the age of 18. Aged 20, he first used LSD, which he describes as his favourite drug. He has also used amphetamine, barbiturates, cocaine, ecstasy and heroin on occasions but never regularly. In the past he has injected drugs and shared injecting equipment. He has also used alcohol problematically, requiring one inpatient detoxification when aged 29. He describes using drugs as a way to "escape from feelings". In 1997, aged 35, he stopped using drugs because he was feeling paranoid, but reported feeling more depressed when not using. His most recent episode of crack cocaine use started early in 1999. A pattern of using twice weekly with a friend from the day centre developed, costing

approximately £40 on each occasion. He said that his use feels out of control, has escalated and that he spends more money than he intends to. He also drinks about 60 units of alcohol a week. He expressed a concern that his drug use was having a detrimental effect on his relationship because it worried his partner. He also said he did not want to become more paranoid or have to resort to criminal activities to fund his drug use.

10.3.3 Case 1: Initial formulation and hypotheses

Early abusive experiences, childhood illness and problems at school predispose this man to the difficulties he has in managing intimate relationships, a poor self-image, feelings of anxiety, low mood, suicidal ideation and substance use. His behavioural and emotional difficulties are consistent with a borderline personality disorder diagnosis, in particular, his pattern of unstable relationships, impulsivity, including substance use, recurrent suicidal behaviour, affective disturbance and stress related paranoia (DSM-IV 1994). Of note are recent conceptualisations of borderline personality disorder in which early trauma is thought to be causal (Linehan 1993).

His crack use meets the American Diagnostic and Statistical Manual (DSM-IV, 1994) criteria for cocaine dependence. His past substance use and current crack use serve the function of escaping painful affective and cognitive states. This functional aspect of substance use developed in early adult life. This is often a stressful time of transition from childhood to adulthood and also commonly associated with substance use experimentation (Sugarman, 1986; Liese and Franz, 1996). His recent episode of crack use was precipitated due to the reported stress of feelings invoked in psychotherapy but also anger about the loss of benefits. This could be described as "acting out" (Rycroft 1968), that is, the "replacement of thought by action" (pg. 1) and may serve some secondary gain as a communication to professionals of his internal distress. Continued use of crack is reinforced by the induced euphoria and binge use by the drug induced dysphoria (Gawin and Kleber 1992).

10.3.4 Case 1: Intervention planning

Planning the intervention involved tailoring a structured intervention based on four elements to the functional analysis and hypotheses described above. This is an inductive, circular process, each aspect of the intervention having a treatment aim but also facilitating further understanding of the client's presenting difficulties and enabling the testing of hypotheses generated by the formulation.

The main hypothesis was that Case 1 had difficulty managing stress (including negative thoughts and feelings) and that these internal cues triggered the desire to use crack. The implementation and outcome of each element of the intervention is described in Section 10.3.5 with reference to this hypothesis.

A further issue considered at this stage was Case 1's contact with other services. He had a well developed professional support network, including a psychiatrist in a community mental health team, a day hospital and a psychotherapist. Consequently the intervention was focused on crack use, maintained by boundary setting during sessions, avoiding, for example, the exploration of earlier abusive experiences. Given his history, it was acknowledged that a long-term multi-professional care plan would be required to enable him to achieve lasting changes in his interpersonal difficulties and managing affect.

10.3.5 Case 1: Intervention and outcomes

i) Psychoeducational intervention

This involves describing the pharmacological action of cocaine to the client and also covers a variety of harm reduction issues. It is utilised as an engagement and motivational tool, with the aim of enabling clients to understand the psychological aspects of their behaviour, particularly binge use and the experience of low mood, paranoid ideas and cravings (Gawin and Kleber 1992). It is used as a means to demonstrate that the clinician has an understanding of the client's difficulties and may be able to help. The potential for dropping out of treatment is discussed as a motivational issue, linking fluctuations in motivation to attend with the pharmacological action

and pattern of cocaine use. This intervention is backed up with a variety of handouts, including a leaflet that specifies cognitive behavioural strategies for coping with cravings, identifying and avoiding high risk situations and managing negative mood states. This is designed to educate the client about the treatment offered as well as acting as a self help guide. This initial phase is designed to act as a brief "stand alone" intervention, based on the common experience of people dropping out early in treatment, but also on the belief that this contact may be sufficient for people to initiate changes through making contact and utilising the information and suggested strategies (Miller, 1998).

Case 1 was able to use the information presented to reflect on his own crack use. It enabled a further discussion of the functional aspects of his drug use as a means of managing negative cognitive and emotional states. He continued to attend for further sessions.

ii) Motivational interviewing

Motivational interviewing is a set of client-centred techniques designed to explore ambivalence about changing drug use, thus creating cognitive dissonance which is resolved through the client changing his or her drug using behaviour (Miller and Rollnick, 1991). It can also be described as a general approach, which highlights the non-confrontational aspects of this way of working with drug using clients (Rollnick and Miller, 1995). The general approach and specific techniques inform this aspect of the intervention, which are also useful throughout all the treatment stages.

A specific motivational intervention is the use of the decisional balance sheet. It is also used as an assessment tool, both of the client's motivation to change and to clarify the functions of their drug use. Discussing the balance sheet with Case 1 and referring back to it during treatment was very useful. It added to the confirmation of the hypothesis that crack use was functional in managing negative mood states and that using was further reinforced by the induced euphoria. It also enabled a clarification of his reasons for wanting to change his drug use. Although he identified some concerns about the effect of his drug use on himself, the most salient reason for changing was his partner's disapproval.

Following the second session, Case 1 achieved a seven-week period of abstinence. However, it was not unusual for conflict to occur with his partner and this was noted to precipitate a return to crack use. It emerged that, in the context of feeling rejected by his partner, any beliefs about the negative impact of using on his situation were dismissed and the desire to escape from his feelings became overwhelming. There was a self destructive quality to his drug using behaviour and a desire to "punish" his partner which also reinforced the crack use. Beck et al. (1993) suggests that this is a particular feature of clients with a borderline personality diagnosis; that the salience of identified internal motivational self statements or negative consequences may be limited. However, positive feelings about his partner (rather than self) and concerns about the impact of his drug use on her, were fruitfully discussed in terms of motivation and gave a focus for specific interventions (outlined below in the relapse prevention section).

iii) Cognitive therapy

A cognitive therapy component is included to address possible cognitive processes involved in the maintenance of cocaine use. It is based on Carroll's (1998) manual, Beck et al. (1995) and Liese and Franz's (1996) work. It is closely linked to the fourth, relapse prevention component of the intervention, since this also draws on cognitive ideas. Supplementary assessment tools are used to assess specific mood related issues; the Beck Depression Inventory (BDI) (Beck et al., 1961) and Beck Anxiety Inventory (BAI) (Beck et al., 1988).

For Case 1, this aspect of the intervention was particularly useful for exploring the main hypothesis of crack use as a means of managing / avoiding aversive cognitive and emotional states. He scored in the severe range on both the BDI and the BAI. However, I predicted that he would score highly on these questionnaires as a consequence of his history of difficulties in managing mood states rather than as an indication of having specific anxiety and depressive disorders. His mood was noted to fluctuate during the course of sessions and he often expressed suicidal intent. These ideas were actively managed using guidelines produced by the British Psychological Society (Linke, 1998). It was significant that these ideas diminished over time, perhaps because a structured but neutral stance was taken.

Beck et al. (1993) write that negative beliefs about self, a tendency to feel isolated and a black and white thinking style are particularly important issues to address with borderline substance using clients. Although these ideas can be readily incorporated into Case 1's formulation, his contact with other professionals enabled a more specific focus on substance use related cognitions.

Case 1 stated that he used crack to cope with feelings invoked in psychotherapy. However, this was not apparent in his reports of drug use during my contact with him, his contact with his therapist being usefully containing. The main source of stress and trigger for crack use was his relationship with his partner. Conflict led to thoughts related to rejection, abandonment and inadequacy. Although Case 1 found it difficult to label specific feelings, anxiety, anger and low mood were identified. In this context crack use was a means of changing affect, or as Case 1 said, "escaping from my feelings". This confirmed the main hypothesis and led to a shared formulation of his drug use based presented in terms of the cognitive model of substance use described by Liese and Franz (1996). This was drawn out on flip chart paper and used to plan and present a rationale for the specific interventions outlined in the following section.

iv) Relapse Prevention

Relapse prevention covers a broad range of largely cognitive and behavioural interventions often used to help clients to maintain changes in their substance using behaviour. Utilising Marlatt and Gordon's (1985) approach, the aim of this component is to teach clients a set of self control strategies to cope with urges to use. Drug diaries, based on a simple antecedent, behaviour and consequence (ABC) functional analysis are used to analyse triggers to using situations and identify where specific coping strategies such as drug refusal skills, craving management etc. may be required. The work of Annis et al. (1996) is useful as a specific refinement of this process. Two questionnaires they have developed were administered; The Inventory of Drug Taking Situations (IDTS-50) and the Drug Taking Confidence Questionnaire (DTCQ-50) (Annis and Martin 1985). Both questionnaires are based on Marlatt and Gordon's (1985) research outlining common drug using situations (high risk situations). These can be broadly divided into personal

states (internal cues) and situations that involve other people (external cues). The IDTS-50 is used to identify drug using situations and the DTCQ-50 to identify clients' beliefs about being able to cope with these situations without using. This draws upon Bandura's theory of self efficacy (Annis, 1986). In a high-risk situation, a person makes an appraisal of past performance to form a judgment about an ability to cope with that situation. Annis (1996) suggests that this evaluation is central in determining whether drug use occurs or not. These tools are useful for identifying a drug using situation profile, making some measure of clients' coping resources and identifying skill deficits. This can suggest the use of specific interventions.

As indicated in the previous section, Case 1's main high risk situation was conflict with his partner which triggered negative thoughts and mood states. His scores on the IDTS-50 and DTCQ-50 confirmed this, but the generally high scores and consequently undifferentiated profile meant that the questionnaires did not add much to the assessment of these issues. It should be noted that, during the early stages of treatment, Case 1's coped with the death of his father without using crack. At this time Case 1 also discarded drug using paraphernalia and some drug refusal skills were role-played in sessions and successfully used in situations where a friend was applying pressure to buy crack.

When Case 1 used crack he did not fill in his drug diaries although the ABC structure was used in the session. The main focus of the intervention was on managing conflict with his partner without using. This involved the use of standard cognitive therapy techniques and problem solving including: challenging the belief that the only reason for not using crack was his partner's concern, thinking through the consequences of using, recognising the value of changes he wanted to make in his substance use for himself, focusing on his positive achievements, normalising and acknowledging the transitory nature of his negative emotional states. A lapse plan was formulated which included use of professional support networks. Attendance at 12-step (Narcotics Anonymous) meetings was also encouraged. Some of these ideas were encapsulated on a flash card which Case 1 was advised to keep in his wallet.

Since being in treatment, Case 1's use of crack reduced from twice weekly to three discrete episodes of use over three months, each as a consequence of the issues identified above. His contact with the service is being slowly reduced, although a low level of monitoring is being maintained as part of an integrated multi-professional care package. Given the long-standing nature of his difficulties it is expected that some crack use will continue but that his contact with the service will minimise the occurrence to avert a major deterioration in his mental state. The use of the strategies outlined above provides a useful structure to sessions, enables a specific focus on substance use and can be regarded as generalisable coping skills that may be helpful in other aspects of his life.

10.3.6 Case 1: Critical reflections

It could be argued that the efficacy of any substance use related intervention will be limited by the extent to which issues related to Case 1's long-standing difficulties, of which crack use may be a symptom, are addressed. Linehan (1993) and Young (1990), describe treatment approaches to work with borderline clients. However, I avoided this (long-term) work because of Case 1's engagement in psychotherapy. Aspects of these author's writings are, however, useful in reflecting on the clinical work, in particular their consideration of a need for therapeutic boundaries, reflecting on transference issues as well as an accepting and empathetic therapeutic stance. Interestingly, some of these issues are congruent with a motivational interviewing approach (Rollnick and Miller 1995).

Transference issues were apparent early on in treatment. These were manifest in Case 1's positive attachment to me and paranoid ideation about being rejected. While it was useful to reflect on the transference in supervision, during the session these ideas (such as why I yawned) were addressed using basic cognitive therapy techniques. These were effective in refocusing the session on his substance use.

Although Case 1 reduced his drug use and hypotheses based on the formulation were confirmed, I have some scepticism as to what extent this was a consequence of the intervention or of the

non-specifics of the interaction (including the transference). The discussion in Chapter nine and issues raised in Chapter eleven, develop this point further.

10.4 Case 2

Case 2 is a 38-year-old man, who is an owner occupier, living with a crack using friend. He accessed the drug service on advice from a community psychiatrist who had assessed him for depression.

10.4.1 Initial presentation

Case 2 is a smartly dressed man, articulate and easy to engage in assessment. He reported smoking crack cocaine for about 15 months prior to contact and episodes of binge use for about 10 months. He estimated that he had spent £6,000 on crack during this time. He linked his crack use with his low mood and lack of confidence in his work performance, but also suggested that these difficulties predated his most recent episode of substance use.

10.4.2 Background information

i) Family history

Case 2 was born in Canada to parents of Chinese descent who were born in the West Indies. He has a sister who is two years older and lives in America. His parents divorced when he was eight years old and he initially stayed with his father for a year, prior to living with his mother and sister. His mother remarried and Case 2 moved to Wales with her aged 15. He describes not feeling close to his mother. His father still lives in Canada and has a professional skilled job. He also remarried and has one son from this relationship, ten years younger than Case 2.

ii) Personal, educational and vocational history

He reports normal birth and developmental milestones. When he moved to the UK he went to boarding school. He did well in his O-levels, but dropped out of school at the A-level stage and came to live in London, not wanting to live with his mother. He had various temporary jobs and got involved in a squatting scene, but also studied photography at a technical college. He started community housing work in his twenties and continued this work with a London council for five years. In this job he found the politics and personal attacks highly stressful and left, aged 35, to work for a media company as a systems analyst. He currently remains in this well paid-job.

iii) Psychosexual history

He reports heterosexual relationships from the age of 17 and his first long term heterosexual relationship lasting seven years from the age of 24. From his early twenties he has visited prostitutes on a regular basis. He is currently involved with two women. One lives nearby and he describes this as a good, supportive relationship. The other, a Liberian refugee, lives in New York. He met her when aged 31, at a time of low mood, and describes a relationship based on sexual compatibility. She works as a table dancer. Their relationship is unconventional, rarely seeing each other, although there is a suggestion that Case 2 financially supports her. He identified his confusion about these relationships as a factor in his low mood. In addition to these two women, he also has unprotected sex with women he meets in the context of using crack. He did not describe these women as sex workers and was ambiguous about the exchange of drugs for sex in these relationships. He has not visited sex workers since his crack use developed.

iv) Psychiatric history

He was referred to a psychologist when eight years old, at the time of his parents separation because of "odd behaviour". He described having a "breakdown" aged 19 following the end of a relationship when he injected a deliberate overdose of barbiturates and cut his wrists. He reports not having felt suicidal since this time. Aged 31, experiencing stress at work and the ending of a

long-term relationship, he reported an episode of low mood and increased alcohol use. From this time, he reports experiencing episodic low mood and anxieties associated with work. He has never been prescribed anti-depressant medication and his low mood has usually resolved itself.

v) Drug history

He reports experimenting with drugs from his late teenage years. He described this as an attraction to dangerous situations and sensation seeking. He has tried most illegal drugs and injected heroin on a number of occasions in his early twenties. He shared injecting equipment and contracted Hepatitis C at this time. He said he was never dependent on any one substance. He became abstinent when involved in his first long-term relationship at the age of 24 and due to concerns about the health implications of Hepatitis, avoided alcohol use.

He resumed alcohol use when aged 31, resulting in heavy social drinking at the weekends. This was his typical drinking pattern until relatively recently when he stabilised his alcohol intake at around 15 units a week. His primary motivation was a concern about his Hepatitis and the possibility of being offered Interferon treatment. He first used crack cocaine when aged 37. He described meeting a woman he did not know in the street and they ended up having sex and using crack cocaine together. She introduced him to a crack using scene which he described as "exciting and creative". For six months he frequented crack using venues about twice a month. Crack use was often associated with sex, or the potential for sex with different women, in these places. In December 1998 his crack use escalated into a period of binge use, costing £3,000 in six weeks. This concurred with a deterioration in his mood. He barely maintained his professional life over this time, often going to work without sleep, and noted increased paranoid thoughts. He started to reduce his drug use with the support of his partner in 1999, but binged up to £150 worth a night on a number of occasions.

10.4.3 Case 2: Initial formulation and hypotheses

Case 2 meets the DSM-IV (1994) criteria for cocaine dependence. A predisposing factor for

Case 2, for both his low mood and substance use, may be his experience of separation difficulties in childhood. During his early adult life, at times of stress, particularly endings in relationships with women, he has experienced a resumption of low mood and experience of anxiety. Substance use serves the function of alleviating these negative mood states and associated cognitions, as well as being reinforcing as a positive sensation seeking experience. It is likely that visiting sex workers served similar functions to his substance use as well as reinforcing of a sense of feeling attractive.

Precipitating factors in this episode of crack use include doubts about his performance at work and unresolved (attachment) issues in his relationships with two women. Casual sex and crack use have also more recently become associated and reinforcing of each other. As with Case 1 the euphoria inducing effects of cocaine, as well as the subsequent dysphoria, reinforces continued use leading to episodes of binge use.

10.4.4 Case 2: Intervention planning

As with Case 1, the intervention was planned on the basis of exploring hypotheses generated from the formulation within a loosely structured intervention. Since the sexual behaviour and crack use appeared to be associated it was decided to assess this relationship further. As Case 2 was not receiving any other form of psychotherapy, it was considered appropriate to explore the hypothesis that negative basic beliefs underlie his mood and substance use related difficulties. The elements of the structured intervention have been described in Section 10.4, so only the implementation and outcomes of the work with Case 2 are described below.

10.4.5 Case 2: Intervention and outcomes

Case 2 received the standard psychoeducational and motivational intervention. He engaged in treatment and the motivational intervention was useful in clarifying aspects of the formulation outlined above. His desire to seek sexual experiences in the context of his crack use and the mutually reinforcing aspects of these behaviours were clarified. His attachment to the crack using

scene and its difference from his professional life was also noted as a further reinforcing aspect of this behaviour. Through completing a decisional balance sheet it was also apparent that his concerns about his crack use were less salient than the positive aspects noted.

Case 2's scores on the BDI and the BAI were in the moderate and mild ranges respectively. To explore underlying beliefs that were possibly maintaining the crack use, standard cognitive therapy mood and thought diaries were utilised from early on in treatment. However, his compliance with completing the mood diaries was poor and information was principally gathered during the session using cognitive techniques such as socratic questioning and the downward arrow technique (Beck et al., 1993). This was useful in determining that his drug use and sexual behaviour served similar functions: reduced anxiety, alleviation of low mood, a source of excitement and highly reinforcing. These techniques were less successful in revealing potential underlying negative beliefs and dysfunctional assumptions. The functions of the substance use were confirmed through the completion of the Annis questionnaires. Interestingly, his experience of sexual interactions in the context of crack use had reduced as his use escalated. However, their occasional occurrence and the potential that they could occur, was the primary stated reason for continued crack use. This could be understood in terms of intermittent reinforcement.

Since it was difficult to identify underlying cognitions related to his mood and because his attendance at sessions was poor, the focus of the session shifted to identify specific drug related beliefs as described by Liese and Franz (1996). This included the use of basic drug diaries and relapse prevention techniques. Case 2 maintained periods of abstinence for up to two weeks but frequently lapsed. He was readily able to identify practical strategies to reduce the opportunities for smoking crack. These included his partner keeping his cash card and staying away from his flat. However, he also contrived situations so that he could obtain money to use and maintained his connections to his crack using life, including relationships with crack using women and keeping his on crack using tenant.

It was apparent that Case 2 was ambivalent about changing his drug use. This can be usefully understood within the stages of change model, a heuristic for thinking about the process of

behaviour change (Prochaska and DiClemente, 1986). Case 2 could be placed in the contemplative stage, during which people are ambivalent about making a change in their behaviour. In terms of intervening with substance using clients, there is a logic to matching the intervention to the stage of change otherwise resistance will be encountered (Rollnick and Miller, 1995). Consequently, the sessions refocused on exploring ambivalence about using, the use of practical strategies such as avoiding high risk situations and using the support of his partner to reduce his crack use and limit the extent of his binges. This backtracking to a more motivational intervention and refocusing the goal of treatment on reduction of substance use rather than abstinence resulted in better attendance. This work is continuing and will provide the basis for future work which could address underlying issues related to his substance use.

10.4.6 Case 2: Critical reflections

Case 2's convergence of substance use and sexual behaviour presents a treatment challenge. Each is highly reinforcing of the other and his drug using behaviour is initiated in the expectation that sex will also occur. Although it was hypothesised that the same underlying process may be causal in these behaviours, to date this has not been clarified. Schema focused cognitive therapy offers an approach to tackle (hypothetical) core beliefs potentially underlying sexual and drug using behaviour (Young 1990). However, this involves long-term work and a commitment to therapy that Case 2 has not demonstrated. Initiating an exploration of these ideas early in treatment was based on the desire expressed by Case 2 expressed to address his low mood but also on his relatively high level of social functioning. However, given the extent of his crack use, it was necessary to shift the focus of the intervention to more basic drug reduction strategies and use motivational interviewing techniques to discuss ambivalence about changing this behaviour.

10.5 General critical reflection

In the following sections the work with these two clients is considered at a more general level in terms of the use of functional analysis, how this may be reconciled with structured interventions and in order to identify common underlying processes that could inform a model of crack using

behaviour.

10.5.1 Functional analysis

The two cases presented in this chapter have similar presenting problems, fulfilling the DSM-IV (1994) diagnostic criteria for cocaine dependence. However, this diagnostic label offers little help in determining the best way to intervene. Functional analysis, as described by Owens and Ashcroft (1982), offers an alternative to a traditional diagnostic method of assessment. The emphasis is on examining what function the problem behaviour serves for an individual through carrying out what Scragg (1996) calls, an "idiographic assessment" (pg. 277). This is the basis to determining the most appropriate treatment strategy. The interventions with the two cases presented varied as a consequence of the use of this assessment strategy. Another advantage of functional analysis is that it allows multiple problems to be considered and relationships between them explored (Owens and Ashcroft, 1982). The two cases presented in this chapter indicate how concurrent difficulties are bound up with and reinforce the substance using behaviour. Understanding these relationships is important in devising the most appropriate intervention.

Although the use of this approach may be criticised as being based on the subjective impression of the clinician, hypotheses may be tested through the use of standardised questionnaires (Scragg 1996). The question of empirical validation of this approach is complex. However, using functional analysis to develop a formulation and hypotheses for each client provides a reflexive structure to planning and implementing interventions and evaluating outcomes. Based on this experience, the functional analysis can be refined and hypotheses reformulated. This process provides a useful structure to clinical work which may be scrutinised in peer review and supervision. This is congruent with the *evidence-reflexive* position of Nieboer et al (2000) which they contrast with that of evidence-based practice. In the following section, the reconciliation of this approach with the use of a structured intervention is described.

10.5.2 Structured interventions

In Chapter eleven, psychological treatments for problematic cocaine use are considered. A broadly cognitive behavioural approach is that most frequently utilised. Manuals are now available which describe a structured psychological intervention for substance use and are useful as examples of applied theory. Carroll (1998) has written one for treating cocaine use. This is essentially cognitive behavioural and integrates ideas from relapse prevention as devised by Marlatt and Gordon (1985), as well as motivational interviewing techniques developed by Miller and Rollnick (1991). The development of manuals has coincided with the search for evidence based interventions and the dissemination and operationalisation of promising techniques.

The two cases presented in this chapter received a structured intervention based on work of proven efficacy as well as reflexive clinical experience. It is based on four elements as described in Section 10.3.5. The development of this intervention was a consequence of seeking a more systematic approach to treatment of cocaine use, enabling the stimulant clinic team to reflect on their clinical practice. However, it was designed to be implemented in a way that was flexible and tailored to suit each individual client. In this sense it can be thought of as a guide or a menu of interventions that can be selected as appropriate. Applied in this way, the structured intervention is consistent with the use of functional analysis as the basis to the process of assessment and treatment planning.

The way that functional analysis is described in this chapter does not tie the use of it to a single theoretical position, (systemic ideas, for example, could be incorporated into this way of thinking). Nevertheless, the ideas implicit in the functional analyses of the two cases are essentially cognitive behavioural. Although this is congruent with the treatment approach, it is the process of using the functional analysis that determines the intervention rather than a prescriptive and rigid adherence to a manual. This process is based on the (untested) belief that a prescriptive treatment approach is not a substitute for good clinical assessment and reflexive practice.

The cases presented in this chapter illustrate how a structured intervention was implemented and

revised based on the individual formulation. In the final section of this chapter, possible underlying processes significant in the two clients' development of problematic crack use are considered with reference to theoretical models of substance use.

10.5.3 Common processes and models of problematic cocaine use

The two cases presented in this chapter, although different in their level of functioning and developmental profile, also share some similarities. These are briefly considered to reflect on possible common processes in the development of problematic cocaine use with reference to the cognitive developmental model of substance use proposed by Liese and Franz (1996) and other cognitive theories (Beck et al., 1993; Young 1990).

These authors suggest that early developmental experiences are important in determining a risk profile for later substance use and refer to core beliefs or schemas underlying this process. Case 1's early abusive experiences and, to a lesser extent, Case 2's separation difficulties in his childhood could have led to core beliefs related to, for example, feeling unlovable, defective or worthless. The activation of these beliefs is aversive and may be avoided through various cognitive and behavioural processes including substance use (Young 1990).

Liese and Franz suggest that, in the context of exposure and experimentation with drugs, specific drug related beliefs develop. These are based around the function of the substance has in alleviating distress caused by the core beliefs. Tonneato (1995) describes beliefs about the function of drug use as metacognitions. Problematic substance use is at risk of developing when it is used in the regulation of affect and more specifically as a means of inducing an intoxicated state which enables an escape from internal discomfort (negative thoughts and feelings). Through repeated use, the drug related beliefs are reinforced. This increases the likelihood of problematic drug use occurring.

Both Case 1 and 2 developed problematic patterns of substance use in late adolescence, which is commonly related to experimentation with drugs. This is also a time of individuation, transition

and association with anxiety (Sugarman, 1986). It could be hypothesised that the stress of this time and, for Case 2, the break-up of his first relationship, led to the activation of core beliefs and the use of substances to escape the consequent aversive feelings. Case 1 stated that he used substances to escape painful feelings. His long history of substance use and contact with psychiatric services suggests this process may have been occurring. Case 2 had significant periods of abstinence in the context of stable relationships. Substance use (alcohol) resumed when this relationship ended, when, in terms of the ideas presented, aversive core beliefs may have been activated, triggering drug related beliefs and substance use.

An understanding of substance use in terms of schemas and specific drug related beliefs offers one potential explanation for the development of problematic use in the two clients presented. However, there are problems in applying these ideas to the work with these two clients. Liese and Franz's model is based on the existence of core beliefs or schemas that are relatively inaccessible to conscious thought. Although they may be incorporated into a functional analysis, it is difficult to test hypotheses generated from these ideas. Young (1990) has developed tools to elicit schemas even though schemas are, in essence, hypothetical constructs. Work at this level tends to be a long term process and due to the specific context and focus on substance use, it is appropriate to work initially with clients at a level where cognitions are more accessible. Tonneato's (1995) model of psychoactive substance use and Marlatt and Gordon's (1985) model of the relapse process offer alternative models based on more accessible cognitions which also lend themselves to practical intervention strategies.

A second concern with these ideas is the problem of reifying cognitions and focusing on them at the expense of potentially more salient influences. In particular, the psychosocial context of people's experience can be overlooked and dismissed at the expense of a focus on internal processes (Smail 1993). The cognitive developmental model could be described as a deficit model in which the problem of problematic use can be understood by looking within the individual. This would suggest that severity of use would be the best predictor of treatment outcome. However, Ashton (1999) writes, in relation to the findings from Project MATCH, that the best predictors of outcome are access to social and community resources.

Taking a broader view of a person within their context lends itself to different interventions which may be of some utility and can be incorporated into a functional case conceptualisation of drug using behaviour. In relation to these two clients, an example of a proximal influence that may be usefully explored is the relationship with their partners. There are now well developed interventions that utilise partners as a source of social support and reinforcement (Budney and Higgins, 1998). In terms of the clients presented, work with Case 1 was integrated into a multi-professional support package, including the use of day care services and vocational training. Taking a more holistic view of a client and his or her substance use and intervening at different levels may be an important part of facilitating longer-term changes.

The ideas discussed in this section have been used to illustrate how clinical work may reflect on theoretical models and their utility in practice, particularly how theoretical concepts may be integrated and tested through a reflexive assessment and treatment process.

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Section D

Critical Review

Psychological interventions with cocaine users

Chapter 11 Psychological interventions with cocaine users: A critical review

11.1 Introduction

Over the last 20 years, in both North America and the United Kingdom, there have been significant increases in the number of people using cocaine (National Institute of Drug Abuse, 1987; Task Force Review, 1996). Perhaps not surprisingly, there have also been increases in the number of people seeking help for their cocaine use from drug treatment agencies (Strang et al., 1990; Task Force Review, 1996). Meeting the treatment needs of this new group of drug users has been a challenge to treatment agencies, particularly those set up to work primarily with opiate users.

This chapter examines the research literature on psychological treatments of problematic cocaine use. The rationale for a psychological approach is outlined, followed by a description of the critical perspective of the review. This is based on evidence of effectiveness, internal validity and the extent to which the results of the research may be generalised to an NHS outpatient treatment setting. The review of the literature is structured to consider four broad outcomes that appraise the extent to which an intervention is effective in: i) engaging cocaine users; ii) retaining them in treatment; iii) assisting them to reduce their cocaine use and iv) enabling them to maintain these changes. The chapter ends with a practically orientated conclusion of what a clinician may take from the literature to apply in a clinical setting.

11.1.1 Identifying the literature

Research was identified using key word searches in the Medline and Psychlit databases. The Cochrane Database of Systematic Reviews (1999) was also used and revealed that no systematic reviews of psychological interventions with cocaine users had been undertaken. A specific literature search request was made to the Institute for the Study of Drug Dependence. Further studies were identified from references in articles found during these searches.

11.2 Why the psychological treatment of problematic cocaine use?

A treatment based on psychological principles is suggested for a number of reasons and these are outlined below.

11.2.1 Lack of an effective pharmacological intervention

It could be argued that treatments for opiate users are essentially pharmacological and that these interventions have a role in attracting and retaining opiate users in contact with services. However, pharmacological interventions with cocaine users such as substitute prescribing and drugs used to alleviate withdrawal symptoms, have not been demonstrated to be effective for cocaine users (The Task Force Review, 1996). This requires a reconceptualisation of treatment to one which is essentially psychological.

11.2.2 Physiology and the psychopharmacology of cocaine

The physiological consequences of cocaine use enables an understanding of how problematic use may develop and provides an intuitive rationale to the applicability of psychological treatments. Cocaine is a central nervous system stimulant. The principle action is to block some of the dopamine re-uptake systems. This results in elevated levels of dopamine in the receptor sites and dopamine depletion in the pre-synaptic cells (Strang et al., 1993b). This is thought to occur in the mesolimbocortial neurones which pass from the ventral midbrain to the nucleus accumbens and orbitofrontal cortex of the forebrain, which form part of the brain's reward system. This may explain the reinforcing properties of cocaine and why, in animal studies, cocaine has been found to be a more potent reinforcer than food or sex (Strang et al., 1993a).

In the UK, cocaine is usually used as one of two forms: cocaine hydrochloride or cocaine base, usually referred to as crack cocaine. The former is usually used intranasally and the latter smoked by inhaling the vapours. Crack produces an intense and quicker (lung to brain in five seconds) but

short-lived effect than cocaine hydrochloride used intranasally. In terms of conditioning theory and reinforcement, these differences may partly explain why crack users are more likely to be represented in clinical populations than cocaine powder users.

Most people who use cocaine do not go on to develop problems with their use suggesting the need to consider other factors in the development of problems including environmental influences (Ditton and Hammersley, 1996). However, understanding that the drug has the potential to be highly reinforcing and that this can be conceptualised in terms of learning theory provides a useful basis from which to develop interventions. Learning theory is also useful for understanding patterns of problematic use and cocaine withdrawal phenomena.

11.2.3 The pattern of problematic cocaine use

The pattern of problematic cocaine use, manifest in lengthening episodes of binge use with periods of abstinence, is different from the typical daily use associated with dependent alcohol and opiate use (Gawin and Kleber, 1992; Strang et al., 1993a). This difference was initially thought to demonstrate that cocaine did not produce the same levels of dependence. However, Gawin and Kleber (1992) note that problematic users could refrain from cocaine use until they were confronted with classically conditioned cues, either internal or external, that evoked the memories of cocaine use. The users reported that this gave rise to an experience of euphoria, similar to the cocaine-induced high and cravings to use. Gawin and Kleber suggest that this expression of psychological symptoms is a manifestation of the physiological neuroadaptation of the brain reward systems caused by cocaine.

11.2.4 Cocaine "withdrawal"

Abstinence from cocaine after a period of sustained use does not cause physical complications and the experience of withdrawal phenomena is essentially manifest in psychological difficulties, without the somatic distress that opiate users describe. There is some debate about the experience of withdrawal upon cessation of cocaine use. Gawin and Kleber (1992) observed a "triphasic

cocaine abstinence pattern" among problematic cocaine users. This is described as a "crash" followed by a "withdrawal" and "extinction" phase. Each was associated with particular negative psychological symptoms and difficulties. However, a study by Weddington et al., (1990) of "cocaine addicts" in a residential setting, reports a gradual decrease of signs and symptoms associated with cocaine intoxication rather than the phased changes described above. This suggests that the withdrawal phenomenon is largely dependent on the context within which it occurs. In an inpatient setting it is likely that the cocaine user is not being exposed to cues associated with cocaine use. Carroll et al., (1991a) write that the absence of a medically dangerous withdrawal syndrome indicates that a primarily psychotherapeutic approach is sufficient for most cocaine users.

11.2.5 Maintaining abstinence from using cocaine

Long term abstinent users reported intermittent recurrence of cocaine craving based on cued memories of cocaine euphoria (Gawin and Kleber, 1992). This suggests that successful recovery from cocaine use is based on managing conditioned cravings without relapsing. In a classical conditioning paradigm, if the cue is not paired with drug use, extinction of the craving will follow.

The importance of triggers and cues (in patterns of problematic use, coping with withdrawal and maintaining abstinence) lends support to the importance of the conditioning process and gives a rationale and potential focus for psychological interventions.

11.3 Defining the critical perspective of the review

The aim of this chapter is to explore evidence for the effectiveness of psychological interventions with cocaine users. It focuses on specific types of intervention, study design, issues of validity and generalisability within a broad outcome framework. These are defined further below.

11.3.1 Cognitive / behavioural interventions

The clinical observations of researchers and the lack of effective pharmacological interventions suggest the value of a psychological approach based on principles of learning theory. However, there are many different types of other psychological interventions (see Rawson et al. (1991a) for a wide ranging perspective on "cocaine abuse treatment"). In the research literature, most of the studies focus on the effectiveness of cognitive and/or behavioural interventions which may be compared with others, such as 12-step counselling. For example, there has been little evaluation of the use of psychodynamic interventions. Rawson et al. (1991a) write that "open-ended, non-directive "generic" psychotherapy methods are not useful in treating cocaine dependence" (pg. 473). However, this remains an untested assumption since the effectiveness of an insight driven therapeutic approach has not been evaluated to the extent of cognitive / behavioural approaches. Since the majority of studies in this area research interventions based on cognitive behavioural principles and because there is an intuitive rationale in their relevance for treating cocaine use, they form the focus of this review.

11.3.2 Study design and demonstrating effectiveness

In this era of clinical governance and evidence based practice, critical issues involved in reviewing literature can be read in the NHS Centre for Reviews and Dissemination (1996) guidelines. These outline a "scientific" approach to the practice of conducting a systematic review, with the aim of determining the effectiveness of clinical interventions. These guidelines are helpful in identifying some of the criteria by which studies can be evaluated, but they also describe a process that may be best suited to evaluate medical interventions. They suggest that the randomised control trial is the "gold standard" of a study design to determine effectiveness. However, research exploring the effectiveness of psychological interventions has real difficulties in demonstrating the efficacy of one approach over another and in illustrating whether changes in behaviour are a consequence of the intervention. The findings of Project MATCH are a good example of this (Project MATCH Research Group, 1997). It is one of the most well designed and costly studies in the addictions field and although, not specifically designed to demonstrate effectiveness (of alcohol treatments),

produced inconclusive results in relation to the effectiveness of different interventions and only limited findings around the main hypotheses. Therefore, studies other than randomised control trials, with less internal validity, are included in this review.

11.3.3 Internal and external validity

Project MATCH is also a good example of how a focus on the internal validity of the study may sacrifice external validity; that is the extent to which the results may be generalised to different (non-research) settings (Ashton, 1999). Few studies exploring the effectiveness of interventions with cocaine users equal the rigour of the study design of Project MATCH and it would be easy to focus on the deficiencies of the research without thinking about what may work and be usefully applied in a clinical setting (Wells et al., 1994).

It is worth noting that all the studies included in this review are from North America, usually from well established academic departments that research drug related issues. The extent to which the results of these studies may be generalised to the NHS in the UK is questionable and considered through this review.

11.3.4 Defining outcome

An excellent and highly detailed review of key cocaine treatment studies specifically focusing on study design and validity issues can be found in the summary article of Acierno et al. (1994). However, this chapter aims to take a broader view of the research and consider effectiveness in terms of four outcomes. These are based on my concerns as a clinician working with cocaine users. First, whether the people who approach the service for treatment come back to a full assessment appointment. In research this equates to the percentage of people who take up treatment compared to those offered treatment. Secondly, whether the people assessed come back to subsequent (treatment) appointments. In the research this refers to retention rates and the percentage of those entering treatment that complete treatment. Thirdly, whether people change their cocaine use while in treatment. In the research, changes in cocaine use are a fundamental

aspect of the studies, although what constitutes a change in cocaine use (length of time abstinent, days of use, amounts of use) varies between studies. A final outcome is whether changes people make in their cocaine use are maintained over time. Some studies attempt to follow up cohorts over time, although the follow-up process and time-scale varies considerably. These overlapping areas provide a structure to the following review.

11.4 Engaging and retaining clients in treatment

Most studies report high drop out rates of cocaine users from treatment and the engagement and retention of cocaine users to maximise treatment exposure is considered crucial to long-term outcomes. Research has indicated that there is a positive relationship between length of treatment exposure and reduced cocaine use relapse rates (Gainey et al., 1993; Simpson, et al., 1999). Carroll (1999) states that "retention has become more or less a proxy for treatment success" (pg. 505). Gainey et al. (1993) and Crits-Christoph and Siqueland (1996) provide useful reviews of retention rates across a number of studies. However, assuming that retention in treatment and changes in drug use are causally related may be misleading since changes may be due to other factors such as client motivation (Wells et al., 1994). Miller (1998) suggests that the "taking of some action toward recovery is a general predictor of change" (pg.165), although the action could be engaging with a placebo condition or an active intervention. A final caveat to unquestioningly assuming that retention is positively related to outcome is that clients who drop out of treatment may also be the most difficult to contact in any subsequent follow-up. Therefore the extent to which they may have changed their drug use (without treatment) may be missed.

Why clients may contact and engage in treatment is likely to be due to a multiplicity of factors. To understand this, a broader consideration of why people may approach treatment agencies and how people change behaviour would be necessary. This is, however, beyond the scope of this review. Nevertheless, some of the studies reviewed consider treatment in terms of its acceptability to clients, while others provide data on numbers of people who contact but drop out before or at an early stage in treatment. A final factor on which studies have focused in relation to retention are client characteristics.

11.4.1 Uptake and early engagement of clients in treatment

Much of the literature reviewed indicates significant client drop-out rates early on in treatment. For example, Kleinman et al. (1990) found that of a sample of 148 crack smoking clients, 42% dropped out after completing research assessments but before receiving outpatient treatment. This is not unusual among the studies reviewed, particularly in publicly funded programmes.

This raises an important point regarding the extent to which results from North American studies can be generalised to the NHS in the UK, or meaningfully compared with each other. In the US, research tends to focus on distinct populations, either those in publicly funded, army veteran or insurance funded programmes. Each is different in terms of client characteristics which potentially impact upon the outcome of an intervention. Differences include, ethnicity (with more African Americans in the public programmes), age, gender, length of education, the type of cocaine and route of use, years of employment and level of income. These factors may make a difference in terms of engagement and retention rates. For example, Monti et al. (1997) report that, in an insurance funded programme, accessed by relatively well educated and working clients (n=145), 11.7% dropped out before being assigned to a treatment condition and a further 14.5% dropped out during treatment, usually over the first three sessions. In contrast, Kleinman et al's. (1990) study referred to above, found that of those who attended at least one therapy session, 58% had dropped out by the sixth session. Only 25% were retained for as many as six treatment sessions. Therefore, the extent to which the findings from these studies may be generalised to different settings is difficult when studies draw their participants from such distinct populations.

11.4.2 Attrition during the research assessment phase

A second issue to consider is the assessment requirements of some of the studies. The large drop-out rates in this phase call into question the extent to which the final treatment populations are representative. Since many people drop out during an assessment phase it is difficult to ascertain the extent to which they differ from those who engage in treatment. Crits-Christoph et al. (1999), report the results of a multi-site study examining the efficacy of four psychosocial treatments.

This provides some interesting data in relation to engagement in treatment. An initial telephone screen of applicants found that 1777 people met the basic criteria for the study. Of those eligible, 937 (52.7%) attended a first visit and 870 started a pre-treatment orientation phase. Differences between those who attended and those who did not are not specified. Of the 870 who started, 383 (44%) did not attend enough assessment or orientation appointments to be eligible for the study, leaving a sample of 487. However, this 44% did not differ from those who engaged in treatment in terms of severity of cocaine use and mental health diagnoses. The important point is that, of those eligible after the initial point of telephone contact (and excluding those who attended an initial visit who were later excluded for not meeting the study inclusion criteria (n=13)), only 27.6% actually engaged in treatment. This is a sobering result for a clinician in the NHS who may feel disheartened if only one-third of their clients make it back to the clinic after initial contact.

11.4.3 The research assessment as active "treatment"

Another point emerges if the outcomes of Crits-Christoph et al's (1999) study are scrutinised. Carroll (1999) writes that most of the reductions in cocaine use occurred in the initial orientation phase, suggesting that this alone could be considered as an intervention, with the actual treatment conditions being an additional treatment. This was also found in Project MATCH. Most clients reduced their drinking in the first week of treatment after an eight-hour contact assessment phase for the study (Ashton 1999). Another finding from MATCH that may be relevant to the outcomes and rates of engagement reported in the study by Crits-Christoph et al. is that client readiness to change is the best predictor of outcome, suggesting that it is something about the client rather than the treatment which is significant to the outcome (those who engage in treatment want to change so treatment appears to "work").

11.4.4 "Acceptability" of treatment

Another way of looking at initial engagement is how acceptable the treatment is to potential clients. Most studies do not consider this, although an exception is Anker and Crowley's (1984)

study which investigated the use of contingency contracting for cocaine users. The study necessitated participants to agree to a contract whereby cocaine use would be disclosed to, for example, a manager at work. Consequently it was deemed unacceptable to 52% of the original sample (n=67). In relation to more standard treatments, it would be interesting to follow up potential clients who make an initial contact to determine whether this was sufficient to make a change in their cocaine use, or whether there was an aspect of the service, therapist or treatment offered that influenced their decision not to attend subsequent appointments.

11.4.5 Summary: Engaging cocaine users

Cocaine users appear to be hard to engage in treatment. It is not possible to ascertain why this might be as most studies do not investigate treatment acceptability. There do appear to be differences in engagement rates among different study populations, with better resourced people more likely to engage in treatment. The need for pre-treatment attendance to fulfil the assessment requirements of studies may be another issue to consider, either because it has the potential to act as an active treatment or because it may screen out the less motivated people. It is difficult to make any definitive statements about client characteristics and engagement since people who do not attend may not have fulfilled enough assessment information compared with those who do engage.

11.5 Retaining clients in treatment

Studies looking at retention have approached the issue from different perspectives. These include simple reports of programme outcomes, comparison between different interventions and enhancing treatment conditions. Part of the difficulty in discussing the issue is that the criteria by which a participant is deemed to have completed a programme vary as does the length and intensity of the programme. This has implications for the extent to which a good retention rate can be considered a successful outcome. The point raised above about assuming that retention in treatment is associated with better outcomes is also relevant.

11.5.1 Outcomes from treatment programmes

Some studies claim good retention rates. For example Washton and Stone-Washton (1990) report a 75% completion rate in a sample of 40. However, the sample size is small and the study did not have a matched control group. Again, sample characteristics are important to consider. In Washton and Stone-Washton's (1990) study, 90% of the participants were employed and insurance funded which suggests a relative degree of positive social functioning as well as motivation to complete a programme. Some insurance funded programmes will fund only a single episode of treatment and this may impact on client motivation. Another issue is that, if cocaine use is "discovered", there may be considerable social pressure to label this as problematic as well as to seek and stay in treatment, particularly among the more affluent. Thus non-problematic users may be pushed to seek treatment which appears to work and falsely enhances its efficacy (Ditton and Hammersley 1996).

Further to Washton and Stone-Washton's (1990) study and due to the intensive multi-component nature of this programme, it is impossible to state which, if any, of the components of the programme were effective in retaining clients in treatment. Rawson et al. (1991b) also report outcome data of a similar structured, intensive out-patient treatment programme to Washton's. Outcomes were compared across two sites which serve different communities. A number of issues emerge from this data that are manifest across most of the studies reviewed. There are better retention rates in the more socio-economically advantaged client group (n=172), with high drop-out rates in the early stages of treatment (20%) and poor completion rates (22%) in the less advantaged client population. The more advantaged Beverley Hills clinic (n=314) had an almost 50% completion rate.

11.5.2 Enhancing treatment intensity

Both the studies mentioned above were based on intensive structured day programmes, but the lack of control groups make it impossible to examine whether this intensity is an important facet of treatment. One of the earliest studies investigating retention among cocaine users is a study by

Kang et al. (1991). Of 168 participants, only 26% attended six or more weekly treatment sessions. The authors hypothesise that this level of treatment intensity was insufficient to retain cocaine users in treatment (See Carroll and Rounsaville (1995) for a detailed critique). Since the key study of Kang et al. other researchers have attempted to test their treatment intensity hypothesis. For example, Hoffman et al. (1994) found that the addition of components such as individual and family therapy had a significant positive impact on treatment retention in a group of inner city crack cocaine users. They found that 38% of the clients (n=50) attending an intensive group therapy programme (five times a week for 120-minute sessions) were in treatment after three months compared to 14% of those receiving the standard treatment package (twice weekly 90-minute sessions) (n=50). They also note that any enhancement to the standard treatment package, including individual psychotherapy and family therapy, increased retention. Although there were twice as many potential contacts available to those in the intensive programme, there was a fourfold difference in average treatment exposure compared to participants in the standard programme (23.4 contacts versus. 6). This study demonstrates that increasing the number of potential contacts may increase retention, however, data is not reported to explore any association of this with improved outcomes.

11.5.3 Retaining clients in treatment: Differences between treatments

A number of studies have compared retention rates between different treatment conditions. For example, Carroll et al. (1991a) assigned 42 cocaine users to either a relapse prevention intervention or interpersonal psychotherapy once a week for 12 weeks and 55% of the sample completed nine sessions. Half of those who dropped out of treatment did so after the first session. Although more clients (67%) in the relapse prevention condition completed the treatment compared to those receiving interpersonal psychotherapy (38%), this was not statistically significant. This may be due to the small sample size but. in a similar study, Wells et al. (1994) report no significant differences in retention between a relapse prevention group and a 12-step group programme. Retention rates for both groups were poor; the mean number of sessions attended for both groups (n= 110) was less than 50% of those offered. Again, most of the drop-out occurred at the beginning of treatment.

Both the study by Wells et al. (1994) and that of Carroll et al (1991) studies were with a well resourced client group. In contrast, a study by Maude-Griffin et al. (1998) of a group of urban crack cocaine users (n=128), with minimal exclusion criteria to participating, not surprisingly reported worse rates of retention. Of a possible 36 group contacts and 12 individual cognitive behaviour therapy (CBT) or 12-step sessions, the mean attendance for groups was 14 and for individual sessions five. Only 17 clients attended 75% of sessions offered. There were no differences between CBT and 12-step in attendance.

Crits-Christoph et al. (1998) compared four different treatment interventions: i) individual drug counselling, ii) cognitive therapy iii) supportive expressive therapy all of which occurred with group drug counselling and iv) group drug counselling alone. Participants attended significantly more sessions in the cognitive therapy and supportive expressive therapy cohorts compared to those receiving the individual drug counselling intervention. However, mean attendance was low across all these conditions. Of a possible 34 contacts the mean group attendance ranged from 11.9 in the individual drug counselling condition to 15.7 in the supportive expressive therapy condition. This is comparable to the results of Maude-Griffin et al. (1998) despite the use of tighter client exclusion criteria.

In contrast to the above treatment interventions, Higgins et al. (1993) compared a multi-component behavioural treatment programme with a 12-step counselling regime. Of the 19 patients who received behavioural treatment, significantly more attended 12 weeks (85%) and 24 weeks of treatment (58%) compared to those who received counselling (26% / 11%). Although this study has a small sample size, the participants in the behavioural programme were five times more likely to be retained in treatment compared to the 12-step counselling group. This may be because the intervention rewarded attendance. However, the fact that this sample contained few crack cocaine smokers and was drawn from people living in rural Vermont suggests some difficulties in generalising these results to inner city populations of crack users. Foote et al. (1994) utilised some elements of the approach of Higgins et al. by including a positive reinforcement paradigm in the treatment of inner city methadone maintained cocaine users. From a sample of

77, 63% of the clients were retained in treatment at six months. It should be noted that clients were also receiving a methadone prescription and there was no control group. The work of both Higgins et al. and Foote et al. is notable in their explicit inclusion of interventions to enhance retention.

11.5.4 Retaining clients in treatment: Client characteristics

Many studies do not obtain outcome data on clients who drop out of treatment. This can introduce a bias in comparing treatment conditions by only considering those clients who remained in treatment at the end of the intervention (Crits-Christoph and Siqueland, 1996). Kleinman et al. (1992) report five general classes of variables that have been examined to distinguish clients that leave from those who stay in treatment. These are sociodemographic characteristics, treatment history, psychiatric symptomatology, level of deviant behaviour and level of drug use. However, research that focuses on client characteristics as predictors of treatment retention have produced inconsistent results. For example, Gainey et al. (1993), in a population (n=110) of mainly white intranasal cocaine users, explored client characteristics and retention. Of these, 43.6% were defined as being retained in treatment, attending half of the sessions offered. A model is drawn from the data that could account for variance in retention rates. Living alone, poly-drug use, shorter length of cocaine using history and no legal pressure to receive treatment were associated with not completing treatment. A difficulty in generalising from this study is that the model can only be relevant to the sample from which it is derived. For example, the population in the study by Gainey et al. is very different from that in the study by Hoffman et al. (1994). They found in a sample of predominantly African American crack smokers (n= 303), that programme characteristics were more important determinants of treatment retention than individual variables (such as client demographics, mental health markers, diagnosis of antisocial personality disorder and alcohol use).

One notable finding in the study by Carroll et al. (1994a) related to client characteristics and retention is that treatment completers were significantly more likely to be married or cohabiting. This suggests the potential importance of social support in determining whether a client stays in

treatment.

11.5.5 Summary: Retaining cocaine users

Retaining cocaine users in treatment is a challenge to service providers and may be important to consider, particularly since length in treatment is positively associated with good outcomes. However, this may be a misassumption since most of these studies do not have a no-treatment control group. Nor does it mean that treatment is necessarily the active determinant of why people change their drug use (Miller 1998). Research on this has been inconclusive. The extent to which some of the studies can be generalised is limited by the lack of matched controls and the characteristics of the sample. The studies do not really address why clients with less economic or social resources do not engage as well as better resourced clients. Higher levels of retention may be related to enhancing treatment programmes. However, the problem with these multi-component programmes is that it is difficult to ascertain which element or combination of elements is critical in retention. In terms of psychological interventions, only Higgins et al. (1993) explicitly utilise psychological theory in designing interventions to increase client retention.

My clinical experience suggests that motivational interviewing techniques may be usefully explored in relation to retaining clients in treatment. A variety of other issues need to be considered in relation to the research. There is growing evidence of the importance of therapist characteristics in the outcome of their clients and it may be necessary to consider therapist motivation rather than that of the clients. An interesting study would be to pay the therapists for the number of sessions their clients attend.

11.6 Changing and maintaining changes in cocaine using behaviour

The core purpose of engaging and retaining clients in treatment is clearly to enable change in their cocaine use. Assumptions about the nature of cocaine dependence and the influence of abstinence orientated approaches has limited the definition of outcomes from interventions with cocaine users, with abstinence being the key indicator of treatment success. This can preclude defining a

reduction in cocaine use as a positive outcome. A discussion of these issues and how they ultimately impact on policy can be read in O'Brien et al. (1992).

In defining which psychological treatment has the best outcomes, Carroll and Rounsaville (1995) suggest that, as with much of the literature on the efficacy of psychological interventions, treatment appears to work but different approaches are equivalent in their effectiveness. Some researchers provide a rationale for interventions based on issues discussed in Section 11.2. These ideas provide a rationale for cue exposure and cue avoidance interventions. Cue exposure can be described as a purer and specifically behavioural approach and cue avoidance is integral to a more social learning perspective central to relapse prevention (Marlatt and Gordon 1985) and cognitive behavioural interventions (Beck et al., 1993). The following discussion considers both behavioural and social learning approaches. However, some of the studies reviewed, particularly those which report outcomes from treatment settings, describe interventions that have a number of different treatment modes. These are referred to as multi-modal interventions and are briefly considered below.

11.6.1 Multi-modal interventions

A recent review of treatments for cocaine users (n=1605) by Simpson et al. (1999) indicates that people who engage in treatment report a reduction in weekly cocaine use. The study settings are varied and the treatments are a mixture of 12-step counselling and psychotherapy in groups and in individual sessions, couple sessions and attendance at narcotics anonymous meetings (as exemplified in the studies by Washton (1989) and Rawson et al. (1991b)). For example, from a sample of 127, Washton (1989) reports that 75% of the 65% who remained in treatment were drug free at three-month follow up.

The main critique of these naturalistic treatment programmes is that, although they appear to work for those who remain in treatment, it is difficult to ascertain whether specific aspects of the programmes were effective or the extent to which changes were a function of the intensity of the programme. However, in contrast to some studies, Simpson et al. (1999) can claim good external

validity since they report outcomes from agencies that do not operate strict research exclusion criteria.

11.6.2 Behavioural strategies

Behavioural strategies can be divided into those based on classical conditioning, such as extinction and stimulus avoidance, and those from operant conditioning principles, such as contingency contracting and community reinforcement (Acierno et al., 1994).

i) Cue exposure

Techniques have been developed with the aim of eliminating the conditioned response to cocaine related cues through a process of extinction. This is done by exposing the client to cues while preventing the self-administration of the drug. Classical conditioning theory suggests that repeated exposure to cues without subsequent drug use should result in the weakening of the conditioning and on subsequent exposure a reduction in the experience of cravings (Rawson et al., 1991a).

A cue exposure study by O'Brien et al. (1990) in an inpatient setting found reported reductions in cravings amongst participants (n= 30). However, this did not reduce the clients' experience of cravings in their home environment, even though the researchers went to considerable lengths to make the exposure as naturalistic as possible, such as the use of videos of the participants' neighbourhood. The difficulty in generalising the impact of exposure from the confines of a treatment centre to the multiple cues for cocaine use experienced in the home environment, remains a problem with this treatment.

ii) Contingency contracting

Another type of behavioural approach is contingency contracting in which cocaine use or abstinence results in a punishment or positive reinforcement schedule. Anker and Crowley (1984)

set up a contract with outpatient clients specifying a punishment contingent upon evidence of cocaine use, such as a letter sent to employers informing them of use. Of the 32 people who accepted this, only one failed to remain abstinent for three months but abstinence was not maintained after termination of the contract. A further problem is that this intervention relies on potential clients having something tangible to lose, such as a job. It also has implications for the role of a therapist which becomes one of policing rather than forming a working alliance resulting in high motivation to conceal difficulties from the therapist.

In contrast to this approach, Higgins et al (1993, 1994a) have developed a contingency management programme which was accepted by 98% of clients to whom it was offered. This may be because it was based on positive incentives rather than contingent punishment. Cocaine use is seen as a case of operant behaviour maintained by the reinforcing properties of the drug. The incentives part of the programme is based on four organising features grounded in the principles of behavioural psychology. These are:

1. Drug use and abstinence being swiftly detected. Regular, supervised urine samples are taken and tested.

2. Abstinence is positively reinforced. Results are fed back to the client, therapist and significant other, immediately after testing. In the first three months of treatment, negative specimens earn points that increase in value with each consecutive negative specimen. Once points are earned they can not be taken away. Points are used by staff to purchase retail items as agreed with the client.

3. Drug use results in a loss of reinforcement. A positive specimen resets the value to a base level.

4. Competing reinforcers to drug use need to be developed. The point system is integrated with counselling based on a community reinforcement approach (CRA). This focuses on four issues:

i. Couple counselling, with the aim of agreeing responses from partner of positive or negative urine results.

ii. Focus on daily structuring of time to minimise exposure to antecedents to drug use.

iii. Employment and vocational assistance.

iv. Integration into new social networks and recreational activities.

Results from this approach have been promising (Higgins et al. 1993). In a small sample size of 38 clients randomly assigned to two treatment conditions, significantly more participants in the behavioural programme (42%) achieved 16 weeks abstinence compared to a standard counselling package (5%). An important finding is that involvement of a significant other in treatment increased the likelihood of abstinence by 20 times (Higgins et al. 1994b).

However, the inclusion of the community reinforcement approach dilutes the extent to which the programme could be described as purely behavioural. Higgins et al. (1994c) addressed this issue in a randomised trial of two groups of twenty clients receiving CRA approach comparing those with and those without the behavioural incentives vouchers. Significantly more participants in the voucher treatment group completed 24 weeks of treatment (75% versus 40%) and five consecutive weeks abstinence (70% versus 50%) than the no voucher group. Although this demonstrates the efficacy of the CRA with vouchers over the CRA without vouchers, the results of the CRA alone compared to other psychosocial interventions are also good. Higgins et al. (1995) also report a 12-month follow up comparison with a control group (n=78). The CRA plus vouchers group maintained better rates of abstinence compared to the control group.

Although the approach of Higgins et al. stands above others in terms of its power to retain cocaine using clients and to produce periods of abstinence, the characteristics of their population sample is important to consider. As outlined in the previous section, the extent to which the

results would be generalised to other settings and client groups with different resources is unknown. A second issue is the cost of the vouchers, these work out to a maximum of $1022 (£600) over six months. It is unlikely that this would be acceptable to most NHS drug treatment services, even though it is comparable to the prescription costs for a person maintained on methadone.

The work of Higgins et al is a good example of applied behavioural psychology and their use of the CRA is also innovative and could be described as a form of environmental behaviourism (Smail 1990): it understands that problems of dependence in terms of cocaine users' relationship with their environment rather than as a deficit within the person. CRA works by facilitating access to social and community resources. Interestingly, in project MATCH these aspects of people's environment had a positive impact on their drinking (Ashton, 1999). This may explain the difference in outcomes noted between those employed, with money and/or family and friends who are supportive of their changes in behaviour compared to those that do not. Maintaining changes in cocaine using behaviour is therefore contingent upon developing competing reinforcers to cocaine use within that person's social environment. In relation to the work of Higgins et al., a three way study comparing a CRA with a voucher only group with a CRA and vouchers group may ascertain the importance of the CRA relative to the vouchers intervention.

11.6.3 Social learning approaches

In this section, treatment interventions based on relapse prevention and cognitive behavioural ideas are reviewed. It is not possible to distinguish relapse prevention from cognitive behavioural ideas. For example, a manual written by Carroll (1998a) described as "a cognitive behavioural approach" reads as a relapse prevention manual based on ideas outlined by Marlatt and Gordon (1985). Relapse prevention is essentially a set of cognitive behavioural techniques with a specific focus on maintaining abstinence. Carroll et al. (1991b) suggest that relapse prevention is particularly suited to working with cocaine users because it can be adapted to suit their specific needs. These include dealing with the psychological consequences of cocaine withdrawal, managing periods of low mood after a sustained period of cocaine use, coping with cravings and

countering cognitive processes that might be associated with a lapse in cocaine use triggering a relapse. Relapse prevention is particularly suited to outpatient programmes since it focuses on symptom control, is flexible to individual needs, fits well with a structured, directive therapeutic stance, is containing for clients and provides clients with a set of skills that can be generalised (Carroll et al. 1991a).

One of the first and most quoted studies exploring the effectiveness of this approach is that of Carroll et al. (1991a) which compared outcome, defined as three weeks abstinence among clients (n=40) assigned to either cognitive behavioural relapse prevention or interpersonal psychotherapy. This found that 57% in the relapse prevention group compared to 33% in the interpersonal psychotherapy group achieved abstinence although this was not significantly different. One finding was that severe cocaine users in the relapse prevention group (54%) were statistically more likely to achieve abstinence compared to those who received interpersonal psychotherapy (6%). This finding prompts the question of whether specific clients are suited to particular treatments. There was also a delayed improvement in terms of cocaine use over a one-year follow up among those who received the relapse prevention intervention compared to those receiving clinical management (Carroll et al. 1994b). Carroll et al. (1994b) suggest that clients may have implemented the generalisable coping strategies learnt through relapse prevention.

In contrast to Carroll et al. (1991a, 1994b), Wells et al. (1994) did not find any differences in changes in cocaine use between people (n=110) receiving a 12-step or relapse prevention intervention. Followed up at six months, both groups reduced their cocaine use and generally the more sessions attended the greater were the reductions.

A study by McKay et al. (1997) found that standard aftercare produced significantly higher rates of abstinence over a six-month period compared to a relapse prevention package. However, if participants had used during the preceding intensive outpatient package, cocaine use was lower among the relapse prevention participants in the first three months of aftercare compared to the standard package. This result was not sustained in the three to six month follow up period. Again these results do not lend support to the superiority of relapse prevention over a standard drug

treatment but the authors did replicate the finding of Carroll et al. (1991a, 1994b) that participants with greater severity of use at baseline did better if they had received the relapse prevention intervention. A specific criticism of the study by McKay et al (1997) study is that in order to enter the treatment conditions a period of inpatient treatment needed to be completed. Since half the participants did not complete this pre-study phase, the remaining sample could be described as more motivated.

Another study by Monti et al. (1997) added a brief coping skills package to an inpatient programme, essentially a relapse prevention intervention. Clients who received this package had significantly fewer cocaine using days and shorter binges compared to a control group over a three-month period. However, the authors themselves suggest that the results might not be generalisable to populations treated in public facilities.

These various studies indicate that relapse prevention interventions work but not necessarily any better than other interventions. Sample sizes in studies are small and characteristics of study populations are representative of more socially advantaged groups. Two other studies are outlined below to address these issues.

Maude-Griffin et al. (1998) compared a 12-step with a cognitive behavioural intervention (CBT) amongst 128 US army veterans. Participants treated with CBT were more likely to achieve four weeks of abstinence (44% versus 33%). Treatment involved group and individual sessions with four possible contacts a week for 12 weeks. The difference between the treatments was maintained at a 26-week follow -up point. The sample in this study is more representative of an urban deprived drug using population. All were crack smoking, 80% were African American and 82% had at least one psychiatric diagnosis in addition to problematic cocaine use. However, they were an older group with long histories of cocaine use and ex-army status potentially accords some protective level of functioning (Robins 1974).

A final study reported is the recent National Institute on Drug Abuse (NIDA) collaborative cocaine treatment study by Crits-Christoph et al. (1999). They compared four treatments in a

carefully designed randomised control trial (n=487) as described in Section 11.5.3. The results of this study indicated that all treatments were effective in reducing the severity of drug use. However, clients in the 12-step individual drug counselling were statistically more likely to achieve and maintain abstinence (59.1%). Differences in cocaine use were maintained between this and the other conditions at six months but there were more similar rates of cocaine use across the conditions at twelve months. Carroll (1999) suggests that the congruence in treatment philosophy between the individual 12-step condition and the group may have assisted in enhancing the efficacy of the intervention.

The good outcomes in this study are comparable to Higgins et al. (1995) even though the sample is more representative of problematic cocaine users that would attend a NHS agency. The study by Crits-Christoph et al also suggests the intensity of sessions is important since the combined conditions had superior outcomes to group counselling alone. It is worth noting that, in the treatment condition with the best outcome, only 36% of clients maintained abstinence for three consecutive months. Thus, although the sample size is large and inclusive, the exclusion criteria utilised in this study and the high pre-treatment drop out rate are important to consider particularly in relation to Maude-Griffin's (1998) study. The changes people made in treatment were also more likely to occur in the early stages raising the possibility that the assessment phase acted as an intervention (Carroll 1999).

To summarise, although treatment appears to work it is difficult to draw any definitive conclusions from the results of these studies about the relative effectiveness of different interventions. One final aspect briefly considered is any matched effects between clients and treatment.

11.6.4 Patient characteristics and outcomes

As already noted, Carroll et al. (1991a, 1994b) suggest that higher severity users may be more likely to achieve abstinence if they receive a relapse prevention intervention, compared to other forms of less structured intervention. Carroll et al. (1994a) and Maude-Griffin et al. (1998) report

that the more depressed participants did better with a CBT approach. However, Crits-Christoph et al. (1999) found no evidence of specific patient characteristics or better outcomes with particular treatment approaches. The tight exclusion criteria resulting in low levels of psychiatric severity in this sample should be noted. Finally, Simpson et al. (1999) report that more severe users require a longer treatment episode before they make changes in their cocaine use. The few matching effects noted may not be surprising given the results from Project MATCH which also found few matching effects and was specifically designed to match alcohol using clients to treatment (Ashton 1999).

11.7 Conclusions: General critique of studies

Taking the body of research reviewed as a whole, it is heartening to see the amount of research generated over a comparatively short time period. It is only relatively recently that problematic cocaine users have been identified in sufficient numbers to warrant investigation, yet a number of different approaches have begun being tested and applied to working with this client group. Generally, the research suggests that psychological treatments work, i.e. that people reduce their cocaine use when in treatment and are able to maintain these changes afterwards. What is less clear from the research is whether one treatment is better than another and for whom, as well as whether it is the treatment that is the significant component in the change process.

It would be surprising if these questions had been answered in the cocaine literature since they remain unanswered in other areas of substance use treatment research as the findings from Project MATCH illustrate (Ashton, 1999). Part of the difficulty may be the lack of no-treatment control groups in the studies reviewed. Carroll et al. (1991a) suggest that control groups are unethical, yet there is evidence that people are able to change their behaviour without treatment (Miller, 1998). Ditton and Hammersley (1996) report that the majority of people who use cocaine do not go on to experience problems and that few require treatment to stop. Changes during treatment may be a consequence of spontaneous remission, in which case any treatment may appear to "work". Ditton and Hammersley's research is a useful counterpoint to that unquestioningly grounded in a "medical approach" (pg.118) which conceptualises cocaine use as

a problem requiring treatment. Exploring how non-treatment populations control and stop their cocaine use may reveal common processes and mechanisms of behaviour change and help to clarify what it is about treatment that enables people to change their drug use (Prochaska et al. 1992).

Ditton and Hammersley's (1996) study also raises the possibility that people who approach services may represent a distinct subpopulation of cocaine users. Ashton (1999) suggests that treatment represents a culturally endorsed way to get better and enables people to use it as a form of permission to initiate changes in their behaviour. The research of Crits-Christoph et al (1999) is a good example of a well designed study in which the majority of participants made changes very early on in treatment or during the pre-treatment assessment phase. This highlights that it may not be the active part of the treatment which leads to the reduction in cocaine use. The high attrition rates in many of the studies reviewed, often very early in treatment, also call into question whether changes in cocaine using behaviour may be related to other factors, such as client motivation, rather than a main treatment effect. A further area that studies fail to consider is the impact of therapist variables on client outcome. There is a growing body of research that outlines the importance of the therapist's approach, especially an ability to communicate empathy, for whether clients change their behaviour (Miller 1998).

A number of issues emerge from the studies reviewed in terms of the extent to which the results may be generalised to an NHS treatment setting. First, all the studies reviewed were carried out in North America. Although there are cultural similarities with the UK, there are also important differences. Cocaine users are not a homogenous group and the research populations vary considerably in terms of their social and economic resources. Some of the studies reviewed draw participants from insurance funded programmes and others from publicly funded research projects. Clearly there are differences in these populations and, not surprisingly, the former tend to stay longer and do better in treatment. This also limits the extent to which different studies and types of intervention can be meaningfully compared. Other differences that make comparisons between these studies difficult include the way that outcomes are defined, the intensity of the programmes and the follow-up times, which are particularly important when there is an indication

of delayed emergent effects in some studies. Although there is now a move towards a manualised approach to interventions, many of the studies do not adequately describe, implement or evaluate the actual psychological components of the interventions (Carroll and Rounsaville, 1995).

Another issue is that few studies approximate to standard clinical conditions although that by Simpson et al. (1999) is a notable exception. There are differences between clinical and research populations as evidenced by the varying exclusion criteria utilised in the studies reviewed. People who are homeless or have a history of psychotic illness are often excluded from studies. Often those most challenging to clinicians are missing from the study populations. A related issue is that participants are also categorised by diagnosis without regard to aetiology which, if considered, might indicate the need for different types of interventions. These participants are excluded to achieve a standard of internal validity. However, the more internally valid a study the less it approximates to a clinical setting.

This leads to a fourth issue concerning methodology. The academic research reviewed forms part of a discipline in which large population samples and the randomised control trial are considered the best type of study. Although some of the studies reviewed do not fall into this category, all report average outcomes in populations. Outcomes are defined in terms of statistical significance which may differ from clinical significance (Roth 1999). Clinicians tend to approach the issue from the other end, i.e. how to manage the individual client. In clinical practice, the single case study represents the application of research findings to practice. This makes it difficult to draw simple conclusions about what may be applied in a clinical setting. Despite this, the final section of this chapter is a practically orientated summary of points that may be drawn from the literature reviewed.

11.8 Conclusions: Applications to clinical practice

This review suggests the importance of viewing problematic cocaine use as different from opiate use and thinking about the specific needs of cocaine users approaching services. A psychological treatment of problematic cocaine use is suggested due to the lack of an effective pharmacological

intervention, an understanding of the physiology of cocaine use, the utility of learning theory to explain patterns of problematic use, withdrawal phenomena and recovery and the primary expression of difficulties in these stages as psychological symptoms. A number of findings from the research reported in this study are useful for clinicians in relation to their clinical practice.

First, they should not be disheartened if many of the clients who approach services do not attend a subsequent appointment. There is some evidence that increasing the number of possible contact points with a client may facilitate engagement. However, a consideration of structural issues such as a low threshold access point to treatment, user-friendly policies that encourage engagement, as well as process issues, therapist approach and manner, are also likely to be important.

Secondly, many clients should be able to initiate change in the early stages of treatment and it would be cost effective to try a brief intervention first. If clients do not respond to this a more intensive approach could follow for a longer period of time. This stepped approach would also be supported by the study of McKay et al. (1997) which suggests that relapse prevention may be particularly useful for those people who continue to use during the treatment phase.

Thirdly, it is important to make contact with the client count since attendance may be poor. A skills training approach utilising cognitive behavioural and relapse prevention ideas could be applicable for providing clients with a set of skills they may be able to use outside sessions. Although there is little evidence that this would be better than any other intervention, there is an intuitive rationale to help people manage negative mood, for example, as a means to help them control their cocaine use.

Fourthly, whatever a clinician does, it should be rigorous, quality controlled and supervised. An important aspect to researched interventions is the extent to which the therapists themselves are scrutinised and this may contribute to changes in client's drug use. This rigour and scrutiny would also benefit clinical practice. While in the NHS this extent of reflective practice may be a luxury, an element of peer review is now expected and easily justified to management. The use of manuals is one aspect of the research which could be used to increase therapists' confidence in

their practice. It is also important that the clinician is familiar with the common issues that cocaine users present and is able to convey this understanding.

A fifth point is consideration of the client's social context. For clients with poor social and economic resources these issues should be actively addressed. Elements of the Community Reinforcement Approach may be utilised in a clinical setting perhaps by bringing in expertise in housing, welfare and vocational issues. Similarly, encouragement to attend 12-step meetings may be important to facilitate participation in a network that would endorse abstinence. The possibility of working with others, such as partners, in the client's social network should also be considered.

A final point concerns the goals of treatment. In the US abstinence remains the unquestioned goal to most interventions, yet most studies report reductions in use as opposed to abstinence. In non-clinical populations, controlled cocaine use is the norm. In the UK controlled use of alcohol has widespread credence as an acceptable treatment goal. It is possible that controlled cocaine use may be an acceptable treatment goal to negotiate with clients as it may enhance retention and fits well within a general harm reduction approach.

Section D References

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Appendices

Appendix A: Semi-structured interview protocols

i) Client interview schedule

1 Use of the service

Initial contact, frequency

Use of service for injecting equipment

Other reasons for using the exchange

- Medical advice and care
- Information about safer drug use, injecting technique
- Access to other services
- Use of telephone
- Counselling and support
- Drop-in, tea and coffee, social contact
- Buying and selling drugs

Typical visit

Changes in service use over time

Perceived value of the service

2 Use of other services

Drug agencies

Pharmacy exchange

Other sources of injecting equipment

Comparisons with service being studied

Perceptions of staff in these agencies

3 Client interactions

Perception of others, quality of interactions

Purpose and function of interactions

Value and importance attached to these interactions / relationships

Development of relationships outside of this setting

Content of interactions, drug related issues

Source of advice, support

Secondary distribution of injecting equipment

4 Other social contacts

Family, partner, drug using and non-drug using friends

Perceptions of support, knowledge of drug use

Source of information about safer drug use

5 Interactions with staff

Perception of their role, quality of interactions

Purpose and function of interactions

Value and importance attached to these interactions / relationships

Perception of staff attitudes, values and beliefs

6 Drug using behaviour

Changes over time

Safer / unsafe use

Reasons for changes in behaviour

Health beliefs

Contact with the service and changes in drug using behaviour

ii) Staff interview schedule

1 Current service provision

Role and responsibilities

Function and purpose of the service

Profile of service users

Perceptions of the ways and reasons why clients use the service

2 Interactions with clients

Example of a piece of work with a client

Characteristics of a working approach

Difference from other services

Perception of interactions between clients

3 Changes in clients drug using behaviour

Role of the service

Work with clients

Appendix B: Key themes identified in data analysis

Explanatory note

The themes identified in the data are listed in terms of the main headings of the client interview schedule and broken down into a series of subcategories. Each subcategory is further divided to clarify each issue and to indicate differences and contradictions within the data. A further main heading is added entitled "Self image" referring to a particularly significant cluster of themes that emerged from the data. Themes from the interviews with the staff are subsumed into these categories and indicated accordingly. Italics denote links to sub-headings. Following these links and integrating the themes into the theoretical framework is the basis to the final stage of the analysis.

1 Use of the service

1.1 Using the service and buying drugs

Initial contact with the service as a consequence of buying drugs: *Buying drugs from other clients.*

Access to service enabled due to proximity to open drug market.

Ongoing contact with the service maintained through continued use of the drug market.

Buying drugs and obtaining injecting equipment as related activities.

The service as a meeting place for buying drugs.

Lack of distinction between the service and the market.

1.2 Use of the service for obtaining injecting equipment

Improvement in access: *Risk behaviour in the context of poor availability.*

Prior difficulties obtaining injecting equipment.

Improved availability and reductions in risk behaviours: *Changes in risk behaviours.*

Barriers to safer injecting:

Poor access to equipment from pharmacies.

Costs of injecting equipment.

Knowledge about risks of sharing not sufficient to change behaviour in the context of poor availability: *Risk behaviour in the context of poor availability.*

Strategies to manage poor availability: *Self image.*

Reusing injecting equipment.

Cleaning injecting equipment.

Increase in frequency of injecting since improved access to equipment.

1.3 Other aspects of the service used

Support for accessing housing: *Practical help.*

The service as an exit point from the drug using world: *Functions of relationships.*

1.4 The service as a source of drug related information

Information about safer injecting and safer drug use: *Staff as a source of information / Other drug users as a source of information about safer drug use.*

Changes in tolerance.

Vein searches.

Medical advice.

The staff as a source of common sense advice: *Client perceptions of staff.*

Client information less reliable, dangerous: *Perceptions of other clients / Self image.*

Staff: Role to counter dangerous drug using practices (like groin injecting): *Working strategies.*

Dangerous behaviours can become normalised in networks: *Other drug users as a source of information about safer drug use.*

1.5 The drop-in

Venue for information exchange: *Buying drugs from other clients / Other drug users as a source of information about safer drug use / Perceptions of other clients.*

The drop-in as a safe environment to interact. *Boundaries.*

Being with your own kind.

1.6 Staff perspectives on clients use of the service

Relationship between service use and buying drugs not as apparent as clients statements.

Younger service users more likely to use the service to meet dealers. *Perceptions of other clients.*

2 Use of other services

2.1 Pharmacy exchange

Ambivalent view of pharmacy exchange.

Absence of verbal support: *Perceptions of staff.*

Shop keeper transaction.

Lack of compassion: *Quality of relationships.*

Drug users have problems and require additional support: *Functions of relationships.*

Working strategies.

Not a place to hang about. *The drop-in.*

Pharmacy exchange opening hours too restrictive.

Not conveniently located near dealing areas.

Restricted opening hours as a factor in sharing injecting equipment: *Risk behaviour in the context of poor availability.*

2.2 Drug prescribing agencies

Contact with private doctors limited to obtaining drugs.

Guarded criticism: *Power and the prescription.*

Contact with prescribing agencies:

Negative interactions with staff: *Quality of relationships / Acceptance.*

Behavioural restrictions: *Working strategies.*

Staff: Power and the prescription. *Acceptance / Working strategies.*

Power imbalance leads to problems in interaction. *Quality of relationships.*

3 Client interactions

3.1 Buying drugs from other clients

Information about the drug dealing market from other drug users: *Using the service and buying drugs / Initial contact with service as a consequence of buying drugs.*

Dangers involved in buying drugs: *Perceptions of other clients.*

The rip off.

Violence.

Structure of the market.

Use of the network: *Perceptions of other clients.*

Support from others when robbed.

Using the network to inform others that a dealer could not be trusted.

Strategies for managing drug dealing transactions: *Use of the network.*

Presenting a tough image.

Arranging protection.

3.2 Secondary distribution of injecting equipment

Altruism:

Concern for others risk behaviours.

Concern for friends: *Selective friendships.*

Strategies to ensure a surplus of injecting equipment. *Changes in risk behaviours.*

Curtail own drug use to enable another to have clean injecting equipment.

Financial benefits.

3.3 Other drug users as a source of information about safer drug use

Practice of drug use learnt outside of the network around the service:

Teachers, mentors and safer drug use.

Interactions on street not conducive to passing information: *The drop-in.*

Information from others about drug availability rather than safer drug use: *Perceptions of other clients.*

Market forces and reticence to disclose information about private doctors: *Drug prescribing agencies.*

Sensible advice from staff contrasted with reckless advice from clients: *Perceptions of other clients / The service as a source of drug related information / Functions of relationships.*

Examples of safer drug use information given to others: *Self image.*

3.4 Perception of other clients

Network as a social scene. *Buying drugs from other clients / The drop-in.*

Network as a changing social environment.

Problems of trust: *Buying drugs from other clients.*

Limited interactions.

The other: *Self image.*

Junkies and negative anti-social behaviours.

Anger towards people who engage in these behaviours.

Younger clients responsible for problems in the network.

The loud minority.

Selective friendships.

Concern and support for friends.

4 Other social contacts

Drug use and social isolation: *Functions of relationships / Quality of relationships.*

Exclusion form social networks due to drug use.

Secrets, lies and problems in relationships.

Separation of drug using life.

Lack of understanding from family.

Strategies for managing the split.

Problems with work.

5 Staff / client interactions

5.1 Formation of relationships

Process of engagement over time.

Staff: Facilitated by low threshold access: *Using the service and buying drugs.*

5.2 Perceptions of staff

Staff as a collective body.

Staff care: *Function of relationships.*

Staff as good people: *Quality of relationships.*

Contrasted with other clients: *Perceptions of other clients*.

5.3 Quality of relationships

Treated as a human not just a drug user: *Drug prescribing agencies / Working strategies.*

Not stigmatised because of being a drug user: *Self image.*

Not judged.

Feeling accepted: *Acceptance.*

5.4 Functions of relationships

Practical help: *Support for accessing housing / Working strategies.*

Staff as a source of information.

Source of support: *Self image.*

When low in mood.

When suicidal.

When drug free.

Source of self esteem: *Normal communication.*

Staff: Provide sympathy and support: *Normal communication.*

Part of a support network.

Friendship.

5.5 (Client) Strategies for engagement

Identification with staff and distancing from clients: *Perceptions of staff.*

Perceptions of similarity: *Self image.*

Perception of staff as ex-users.

Minimisation of professional status of staff: *Normal communication.*

People who understand.

Mutuality and respect in relationships: *Self image.*

Special relationships: *Source of self esteem.*

Relationships based on normal social rules: *Normal communication.*

5.6 Normal communication

Chatting and talking: *Working strategies.*

Football: S*elf image.*

Junkies can only talk about drugs: *Self image / Source of self esteem.*

Honesty about drug using life: *Functions of relationships.*

Staff: Normal communication as: (*Working strategies).*

Non-drug related (positive) communication.

Respite.

A motivator for change.

Fulfilling a basic human need.

A harm reduction intervention.

A strategy of engagement.

5.7 Staff working approaches

5.7.1 Acceptance

Non-judgemental about drug use: *Drug prescribing agencies / Working strategies.*

Abstinence not a realistic goal.

Clients have choices.

Positive attitude to clients.

Negative approach leads to difficult interactions: *Working strategies.*

Negotiation in the staff team when working with difficult people.

Belief in possibility of change.

5.7.2 Boundaries

Minimising professional power: *Drug prescribing agencies / Client strategies for engagement.*

Limits and rules.

Blurring the boundaries to engage clients: *Quality of relationships.*

Negotiation around boundaries.

Relationship as a basis to negotiate boundaries: *Quality of relationships.*

Difficulties maintaining boundaries.

5.7.3 Working strategies

Identifying motivational crises:

Monitoring of clients presentation: *Normal communication.*

Facilitating changes in social circumstances: *Drug using behaviour.*

Harm reduction.

Practical help.

Holistic approach.

Low threshold access:

To injecting equipment.

To support. *Acceptance / Strategies for engagement / Functions of relationships.*

Information and advice: *The service as a source of drug related information.*

6 Drug using behaviour

Risk behaviour in the context of poor availability: *Improvement in access.*

Reusing needles.

Unsterile water.

Sharing.

Risk behaviour when in withdrawal: *Self image.*

Changes in risk behaviour: *Use of the service for obtaining injecting equipment / Self image.*

Cleaning injection sites.

Reductions in sharing.

Use of proper sized injecting equipment.

Cessation of groin injecting.

Reductions in poly-drug use.

Use of sterile water.

Maintaining a regular supply of injecting equipment.

7 Self image

Drug users have problems.

Self as an outsider: *Perceptions of other clients / Functions of relationships.*

Different from others: *Source of self esteem.*

Self as drug user as opposed to junkie: *Source of self esteem.*

Responsibility to the public as a drug user.

Experience and advice to younger clients.

Self as junkie:

Junkies share injecting equipment: *Perceptions of other clients.*

Appendix C: Ethical Information

i) Information sheet

INFORMATION SHEET

PROJECT: The Role of a Needle Exchange in Drug Using Behaviour

RESEARCHER: Luke Mitcheson

This study aims to find out the ways that people use ****.
The study will look at what people do when they visit the ****. It aims to find out if this has in any affected their drug use.

If you are willing to take part in this study you will be invited to discuss why you use the **** and the support it may provide for you. You will be asked about support you might get elsewhere including family and friends.

The interview will be taped and last about one hour. The information you provide will be completely confidential and the only person hearing the tape will be the person who interviews you. You do not have to give your real name to the researcher and the staff at the **** will not be informed of the things you have said. You will be given a £5 shop voucher at the end of the interview for your time.

You do not have to take part in this study if you do not want to. If you decide to take part, you can stop the interview at any time without having to give a reason. Your decision to take part will not affect your care and use of the service in any way.

Please take this information sheet away with you to think about whether you want to take part in the study. If you want further information the researcher is at the **** on Thursday afternoons. At other times you can contact him on: ****.

ii) Participant consent form

CLIENT CONSENT FORM

PROJECT: The Role of a Needle Exchange in Drug Using Behaviour

RESEARCHER: Luke Mitcheson

To be completed by the volunteer: Delete as necessary:

1. Have you read the information sheet about this study? YES/NO

2. Have you had an opportunity to ask questions and discuss this study? YES/NO

3. Have you received satisfactory answers to all your questions? YES/NO

4. Do you understand you are free to withdraw from this study:

at any time
without giving a reason
without affecting your use of this service? YES/NO

5. Do you agree to take part in this study? YES/NO

SIGNED DATE

NAME OR ALIAS IN BLOCK LETTERS

RESEARCHER

iii) Ethical approval

CAMDEN & ISLINGTON
Community Health Services NHS Trust
Your Partner for Health

LOCAL RESEARCH ETHICS COMMITTEE
Medical Directorate, Vezey Strong Building, 112 Hampstead Road, London NW1 2LT
Tel: 0171 530 3055 Fax: 0171 530 3018
E-mail: sue.rodmell@dial.pipex.com

27 September, 1996

Mr Luke Mitcheson
Clinical Psychologist
Hampstead Road Centre
112 Hampstead Road

Dear Mr Mitcheson

Application No: 96/87
Title: The role of a needle exchange in facilitating behaviour change. An investigation of social processes in the context of changing service provision

The Local Research Ethics Committee considered the above application at its meeting on 23 September 1996 and I am pleased to say it has agreed to approve this project.

Please note that the following conditions of approval apply:

- It is the responsibility of the investigators to ensure that all associated staff including nursing staff are informed of research projects and are told that they have the approval of the Ethics Committee.
- If data are to be stored on a computer in such a way as to make it possible to identify individuals then the project must be registered under the Data Protection Act 1984. Please consult your department data protection officer for advice.
- The Committee must receive immediate notification of any adverse or unforeseen circumstances arising out of the trial.
- The Committee must receive notification: a) when the study is complete; b) if it fails to start or is abandoned; c) if the investigator/s change and d) if any amendments to the study are made.

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- The Committee will require details of the progress of the research project periodically (e.g. annually).

With best wishes.

Yours sincerely

Stephanie Ellis
Chairperson