HWNS

On the 4th December 2010 we held a Volunteer Training Day at the Learning Trust in Hackney, this is an electronic version of the Training Manual which was used.

Volunteer Training Course

Manual and Information Pack (Online Version)

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Background Notes for Volunteers

Hackney Winter Night Shelter provides a warm welcome, a hot meal and a bed for 25 homeless people each night from January to March each year. We also help our guests to escape the street and find long-term accommodation. Last winter, 557 volunteers from around Hackney helped to run the Shelter. We are preparing to re-open in January, and we need volunteers to help set up the Shelter, welcome our guests, cook and serve supper, and some to stay overnight and provide a cooked breakfast in the morning.

Seventeen years ago, a group of local Christians, some of who had personal experience of homelessness, were thinking about how they could help the people they saw sleeping on the streets around Hackney. They had the idea that if a group of churches each took responsibility for running a shelter for one night of the week, some of those people could be helped. What started as a loose network of volunteers from local churches collaborating to address a problem on their doorsteps, has developed into Hackney Winter Night Shelter.

Setting the table for supper

Our Shelter operates during the coldest months each year, from the beginning of January to the end of March. We still operate on the same basic principles: the Shelter is at a different church hall each night of the week, and a local team of volunteers provide a welcome, a hot meal and a bed for the night for our homeless guests.

We offer hospitality to those who come to us, and we regard them as guests. We try to provide the best we can with limited resources, and to make our guests feel at home. We think it is important to take time to have a chat with our guests and get to know them. Many have commented on the warmth of the welcome they receive.

We now employ Paul, our Link Worker, full-time. During the day, homeless people can phone him to find out if there is room for them at the Shelter. If there is, Paul explains how to get to the Shelter that evening. If not, he is often able to find callers a bed in other shelters around London.

At the Shelter venue for the evening, some of the volunteer team arrive early to set things up: they put out beds and start cooking supper. Paul arrives to check in those with reserved beds. Our guests get to the Shelter in time for its opening at 8pm (7pm on Sundays), and are welcomed by the volunteers with tea. After they have had a chance to settle in, supper is served. We provide a hot meal and a pudding each evening. Often, the volunteers will eat with the guests.

After supper, there is time for relaxation: watching TV, reading a book or newspaper, playing cards or chess, or chatting. Some of the shelter venues have showers, which our guests make good use of; we provide toiletries and towels.

Watching the Arsenal v Barcelona match

This is also the time when our Support Workers can work with our guests individually, trying to find suitable longer-term accommodation for them. Our Support Workers come to us from Thames Reach, a London homelessness charity, and are full-time specialists in finding the right place for people who have been homeless. In this way we help our guests not only with a bed for the night, but to escape from the streets. Some of our guests have physical or mental health issues or addiction problems, and our Support Workers can assist them to find the help they need.

At about 9:30pm, some of the guests will go off to another “dormitory” hall to sleep; in this way, we can accommodate more people. Last winter, we provided 25 beds each night, split between the main Shelter venue and the dormitory hall.

Tuesday evening cooks

Also at around 9:30pm, the evening shift of volunteers leave and the smaller overnight team arrive. People start going to bed, and we usually put the lights out at about 11pm. The volunteers take turns to get some rest, but at least two will be awake at any time.

People start getting up in the morning around 6:30am. More volunteers arrive at this time to help with breakfast and clearing up. A hot cooked breakfast is ready at 7am.

After breakfast, our guests start to leave, and the volunteers put away the beds and clear up. Usually the halls used by the shelter are used by other groups during the day, so everything must be tidied away. We aim to finish clearing up by 8:30am.

The Shelter venues are spread around Hackney, and each has a team of local volunteers and a coordinator who arranges a rota. We aim to have enough volunteers so people don’t have to be at the Shelter every week. In particular, we try to make sure people don’t have to do overnight shifts more than once a month. We ensure there is always an experienced Overnight Coordinator who is in charge at the Shelter.

We organise training courses for our volunteers, in understanding homelessness, drug and alcohol problems, First Aid, and dealing with aggressive behaviour (of which there is, thankfully, little at the Shelter). We encourage our volunteers to get more involved with running the Shelter – we need people who are prepared to be coordinators, fundraisers and charity trustees.

When the Shelter closes at the end of March, our Support Workers make a huge effort to make sure all our guests have alternative accommodation. Our Link Worker continues to work with those who have found a place to stay in the area, providing day-to-day support for people who may not be used to life off the streets.

We are starting a Befriending scheme, which will enable volunteers to meet regularly with former guests, to provide ongoing social contact. This is another opportunity for volunteers to get involved.

All of these projects come under the umbrella of Hackney Doorways, our registered charity. A group of volunteer Trustees runs the charity, raises funds to support our activities, and makes sure we are meeting all the legal requirements.

An Overview of Homelessness

This paper was prepared by Pete Middleton, Outreach Worker with Thames Reach who has worked with us for the past 3 years

More than just a roof…

The problems faced by homelessness extend well beyond addressing their accommodation needs. Often homeless people experience a combination of other issues which act as an obstacle to getting them off the streets. It is estimated that 50% of rough sleepers have an alcohol problem, 45% a drug problem, 38% have a history of mental illness & 43% have experienced prison at some point in their lives.

The Causes of Homelessness…

In 2007 there was estimated to be around 500 people sleeping rough in England on any single night, around half of whom were in London**.** This represents around 3000 separate individuals over the course a single year in the capital alone.

The causes of homelessness are diverse. For most people there's no single event that results in sudden homelessness, rather it normally results from a combination of unresolved problems building up over time.

Some of the common causes of homelessness include:

Individual factors: including drug and alcohol misuse; lack of qualifications; lack of social support; debts, especially mortgage or rent arrears; poor physical and mental health; relationship breakdown; and getting involved in crime at an early age

Family background: including family breakdown and disputes; sexual and physical abuse in childhood or adolescence; having parents with drug or alcohol problems; and previous experience of family homelessness.

An institutional background: including having been in care; the armed forces; or in prison.

Structural factors: A lack of affordable housing; unemployment; poverty; and problems with the structure and administration of housing benefit.

Many of these factors are long term influences and create the conditions in which homelessness becomes a possibility. A recent study commissioned by *Shelter* found the most frequent immediate reasons for people ending up on the streets were:

- **relationship breakdown:** 41%
- **being asked to leave the family home:** 28%
- **drug and alcohol problems:** 31% and 28% respectively
- **leaving prison:** 25%
- **mental health problems:** 19%
- **other:** for example, eviction, problems with benefits payments, losing your job.

Effects of Homelessness on people's Health…

Those affected by homelessness are more likely to suffer from a range of physical and mental health problems than the general population. There are obvious health implications associated with sleeping out in the cold, as well as affects resulting from long term alcohol or substance misuse. People sleeping on the streets are at greater risk of chronic chest and breathing problems, poor diet and nutrition, stress and depression. Indeed, research by the homelessness charity *Crisis* suggests the average life expectancy of a rough sleeper is just 42 years of age, compared with a national average of 74 years.

Listening Test

		Score
1	I make a great effort to really understand the other person’s world when I listen to them	
2	I do not switch off part way through some speaking, because I feel like I know what are going to say	
3	My close friends would say I am a good listener	
4	I do not finish off sentences for people	
5	I listen not only to a person’s words but I am aware of their body language and tone of voice	
6	When people are aggressive or angry, I am still able to listen without getting upset.	
7	I am able to reflect back the other person’s feelings with empathy.	
8	I do not try to solve the other person’s problem or give answers but I’m able to stay with what they are saying.	
9	When someone shares something I feel I have experience in, I do not cut in with my story but wait until they have finished theirs.	
10	I ask for clarification if something is not clear rather than assume what they mean	
11	I am aware when I am listening of my own personal ‘hot buttons’ that may cause me to be angry, upset, fearful or nervous.	
12	I am comfortable with silence when someone is thinking of feeling something deeply.	

Give yourself 3 points if the statement is always true
1 point if it is sometimes true
0 point if it is not true

Add up your score

If you score 36, you are a saint!

A score of 25 up means you know how to actively listen

A score of 15-25 means you need to work on some areas

A score of less than 15 means you need some serious work to become a good listener

Anyone can improve!

Listening Skills

Our erstwhile Chair, Fr David Evans, compiled these excellent tips on listening skills before the 2009 Shelter opened

It's amazing how much we volunteers can help our guests by listening to them. In 2008, Jay Flynn reflected on his experience of Hackney Winter Night Shelter. He described how he'd been homeless for nearly nine months, sleeping on public transport. During that time he hadn't had a single conversation. When he turned up at HWNS he was welcomed, given a hot meal, a hot shower and a change of clothes. 'But', he wrote, 'the best thing was that I was normal. I wasn't a homeless man, I was just a guy having conversations.'

For Jay, *the best thing* was being listened to. That's something we might all want to bear in mind. It's easy for us to think that what really matters is preparing meals and beds, both of which require a lot of work. But let's not lose sight of the equally important task of listening to our guests.

Start by thinking about how you'd like someone to feel when they're talking to you. Many volunteers might say they'd like guests to feel relaxed, safe and accepted. Listening well allows our guests to feel they have been met or known as people in their own right.

Before starting a conversation:

Think about time and place. Put yourself in our guests' shoes. Would you enjoy a conversation if you were brushing your teeth? Probably not. Would you enjoy a conversation if you were soaked through and hungry? Probably not, except to say how wet and hungry you were. On the other hand, our guests spend a fair part of their time with us waiting: waiting to get into the shelter, waiting for dinner, waiting to go to the dormitory, waiting to go to bed. Those can be good times to talk.

Starting a conversation with a guest who's standing up might be easier than with someone sitting, because it's easier for our guests and for us to end conversations if we're standing rather than sitting, so people are less likely to feel trapped.

Our guests have little to call their own, but they do have the space around them. Try not to trespass by getting too close to them physically. Try not to stand or sit directly in front of someone; instead, stand or sit at an angle, so you're not forcing eye contact. Touch can be wonderfully healing, but use it with caution and stick to forearms or shoulders.

How to start a conversation:

Many of us find it difficult to start conversations with other people, and all the more so with people whose life experience might be very different from our own. But most of our guests aren't really so different from ourselves - we all experience joys and disappointments, success and sadness. Bear in mind that our guests have not always been homeless, and God willing they will not remain homeless for too much longer, so we may have more in common than is obvious at first.

Try to begin a conversation with an open-ended question. If you ask 'Are you very cold?' the obvious answer is 'yes' or 'no', neither of which helps the conversation to get going. If you ask 'How are you finding the weather?' you're leaving the door open for all sorts of possible answers, and those answers open the way for further questions.

Think about how you ask a question. If someone in a call centre asks you ‘How are you this morning?’ you’re unlikely to answer anything other than ‘fine’ because you know they’re not really too concerned about you. It’s quite possible to start a conversation with a guest by asking ‘How are you?’ in a tone that shows the answer matters to you. For that, body language is important – think what it might mean for your posture to be relaxed and open.

All of our guests are unique. If you notice something that looks like it might have a story behind it, you can start a conversation by remarking on it along the lines of ‘I like your nose ring’ ‘That looks like a really useful shopping trolley’ ‘You’re carrying a dog lead. That makes me wonder if you’ve had a dog’.

How to help someone feel heard:

It can be helpful neatly to summarise what someone has just said. If you say ‘So your landlord doubled the rent and you felt really angry’, the speaker will know you were paying attention and can use your summary to take the conversation forward.

What to ask:

If you’re reasonably confident in your ability to respond to other people’s emotions, ask people how they felt or feel about the situation they’ve described.

What not to ask:

Beware of your own curiosity: you’re there to support and assist our guests, not the other way round. The question most volunteers want to ask is ‘How did you become homeless?’ Don’t. It’s none of your business. Like it or not, as a volunteer you’re in a position of power. Bear that in mind, and don’t use it to pry. Nor are you there to judge people. Instead, go gently, and so long as you go gently you’re unlikely to go too far wrong.

Sometimes guests will volunteer very personal information. If they do, don’t feel you need to do anything other than listen. Don’t feel obliged to cheer them up, as that can feel like a denial of how they’re feeling. You can’t waive a magic wand. Just hear what they have to say and hold it in your heart.

How to end a conversation:

We’ve all had the experience of being button-holed by guests who won’t stop talking. If you need to end a conversation, put down a marker: ‘I’m going to need to go in a minute’ allows them to get used to the idea. Then you could thank a guest for taking the time to speak with you or offer the possibility of a further conversation next week. Be firm but polite.

DE 29.11.08

Managing Aggression

What is violence?

Definitions

The Health and Safety Executive's definition of work related violence is

"any incident in which a person is abused, threatened or assaulted in circumstances to their work' (HSE Guide: Violence at Work; a guide for employers).

The DSS Committees of violence

"The application of force, severe threat or abuse, by members of the public towards people arising out of the course of their work, whether or not they are on duty and it includes:

- ⇨ Severe verbal abuse or threatening behaviour
- ⇨ Sexual harassment or abuse
- ⇨ Racial comments or actions
- ⇨ Threat with a weapon
- ⇨ Physical attack causing injury and pain
- ⇨ Intimidation

Violence is not just about being touched!

Why do people get Violent and Aggressive?

There are as many reasons why people become violent as there are violent incidents some of the common causes are:

Pressure: The day to day angst of living. This pressure may be money worries, family or personal problems, the environment the person is living in to name a few. The pressured person may be looking for release by becoming violent.

Stress: This is a single incident that makes the person violent. It may be a small incident that seems worse because of the pressure the person is under (the straw that broke the Camel's back).

Feeling threatened: You merely representing an organisation can make you a threatening person. If you are fairly low in the organisation's hierarchy you may also be perceived as a "safe" authority figure to abuse e.g. people feel safer being abusive to a doctor's receptionist than the doctor.

Feeling unable to cope: The people you are dealing with may have many multiple problems. A demand for payment may be in the list of debts that are already overwhelming them. You serving a notice of seeking possession may create a situation where the person cannot cope any further.

Powerlessness: Many conflicts have their roots in power. A person may feel the need to "get on top" by using abuse, swearing, physical intimidation or actual violence. The person may also want

to "cut you down to size" (to their level) by using belittling remarks or threats to complain about you.

A difference of opinion: The person may have a difference of opinion with you or with someone else. This may be as simple as the standards of service they expect from your organisation or it could be that they believe that they are entitled to something that you do not believe that they should have.

Frustration: A person may be waiting a long time in a reception room. They may be on the telephone listening to "Greensleeves" for 15 minutes before they are put through to you. It may be a neighbour who has had a noisy neighbour. Frustration can easily boil over to violence.

Drugs and Alcohol: These can impair judgement and can increase aggression. It is also important to recognise that at times people may be taking too little or too much of the prescription medication that has been prescribed. This can also create impaired judgement.

Poor physical conditions: This may be conditions such as noise, crowding or the physical condition of the environment in which they live. It may also be inadequate facilities such as ill-equipped reception areas where people are forced to wait for a long time.

Anger: You may be on the sharp-end of a previous exchange with another person or experience that has very little to do with you.

Mental Health issues: Some people suffer from undiagnosed mental health conditions. Some people although diagnosed are not supported adequately or may have refused services. You may find yourself dealing with someone who is violent in these cases.

Verbal Aggression

Many people in the Housing and Social care field have instances of verbal aggression on a day to day basis. It is easy to become so used to this that we underestimate its effects or it's impacts. Dealing with verbal aggression all day gets tiring and stressful. It also means that we may underestimate the risk of it escalating to physical violence.

There are several forms of verbal aggression. The most common are:

Abuse- The person will take something about you that is different from them. It may be a real difference such as your ethnicity, your gender or your age. It may also be something that isn't necessarily real like your abilities and knowledge, details about your private life or economic circumstances. They will use this to attack you with and make it seem as if there is something wrong with you.

What they are attempting to do is to attack you personally so that you will react as a person. Abuse is something that you need to decide whether you can deal with it or not. Racist, sexist or

homophobic abuse for example should not be tolerated and the person should be "referred" to another person.

- ⇨ **Insults**- are another way of attacking you personally. Again the motivation of the person is to attempt to argue with you as a person.
- ⇨ **Sarcasm**- quite often double meanings or words with an "edge" to them, e.g. "I'm sure you will be able help me
- ⇨ **Threats**- there are many different sorts of threats but the most common are "I'll complain" or I'll get you". Sometimes they can even be personally directed such as I'll find out where you live all threats are designed to intimidate, confuse and frighten
- ⇨ **Putdown**- is an attempt to make you feel small and stupid- again designed to intimidate.
- ⇨ **Interruptions**- People talking over you and not listening.
- ⇨ **Shouting**- which is often combined with all of the above.

Physical Aggression

In situations where there is high verbal aggression or the chance of physical aggression, the stress response is triggered. The stress response makes

- ⇨ The heart beat faster
- ⇨ Adrenaline be pushed around the body
- ⇨ Heavy breathing so oxygen can be put around the body

As part of the stress response you are likely to see

- ⇨ Clenched fists
- ⇨ Glaring expression
- ⇨ Finger Pointing
- ⇨ Fist thumping
- ⇨ Folded arms
- ⇨ Fast breathing
- ⇨ Change in face colour
- ⇨ Sweating

The other important thing to recognise is that the body stops thinking and starts reacting when we become angry and aggressive. This means the person is not being calm or rational - they are reacting to your cues.

Calming Strategies

It is important to recognise that you are subjected to violence and aggression only when the other strategies such as risk assessment and precautions have networked.

It is also important to remember that you need to talk your way out if possible. It is also important use strategies that match your personality. If you use something that is not authentic to you it is likely to give the angry/ aggressive person that they are not in a real situation with a real person. Some of the strategies you might like to try are as follows:

- ⇨ **Speak softly:** You are likely to raise your voice unconsciously in a conflict, keep it down so that the person realises that they are shouting.
- ⇨ **Slow the conversation down:** Move people back to the "thinking" rather than reacting. If possible ask them open questions in order to get them to tell you what they are angry about
- ⇨ **Sit down**: If you feel that there is no risk of physical violence, sit down. This will encourage them to sit down as well.
- ⇨ **Open body posture**: Relax! If you show that you are upset or intimidated this will reward them. By acting as if you are not frightened or scared you will make them realise that this is not going to work.
- ⇨ **Open hand movements**: Use calming signals such as open hand movements to calm them down.
- ⇨ **Show you are listening:** Use active listening techniques let the person know that they are dealing with someone who wants to help and wants to listen.
- ⇨ **Don't mimic their behaviour**: As tempting as it is by retaliating, it will only escalate the situation and make the whole situation worse. Even if you manage to "beat them" they are likely to be in a position about your behaviour. It is difficult for organisations to take action against people if their staff can be equally held to blame.
- ⇨ **Ignore Insults/swearing**: Remember these are ways of getting a "rise" out of you. By ignoring them you are likely to be able to calm down the situation. Also remember that there is a difference between swearing and being sworn at
- ⇨ **Maintain eye contact:** Keep looking at the person if appropriate. Our impulse is to either drop our eyes (passive) or stare back (aggressive). Keep the same eye contact as previously
- ⇨ **Let them let off steam:** The more they let off steam, the less builds up. By letting them talk about their anger they are more likely to calm down. Sometimes however, people talk themselves into anger if this is the case then try another tactic.
- ⇨ **Find out what the problem is:** As discussed, people normally have a problem of some description. Find out what it is and try to do something about it. Offer solutions if you can

Reasonable Force

The test of reasonableness in law is

- ⇨ Having sound judgement; fair and sensible: no reasonable person could have objected.
- ⇨ "based on good sense: *it seems a reasonable enough request \ the guilt of a person on trial must be proved beyond reasonable doubt."*
- ⇨ The test of reasonableness in law is what is commonly considered as sensible under the situation. The problem is that there are no definite parameters and absolutes
- ⇨ It can be very difficult to judge in a stressful situation what is reasonable or not. It is therefore always advisable to leave a potentially violent/ violent situation before "reasonable" force is required.

HD/HWNS Confidentiality Policy

A. POLICY STATEMENT

As people offering support to individuals who use this Service, we will be privileged to know personal information. This is a relationship of trust, which needs to be respected. Information gained about people must be treated as being confidential

B. CONFIDENTIALITY DEFINITION

Confidentiality is maintaining the security of information obtained from or about an individual, which has been gained through a professional/working relationship. This information can only be shared in restricted circumstances such as when there is a legal compulsion or it is required to ensure the well being of the person. Some information will need to be shared with people/agencies who directly contribute to the provision of services and who are, they, bound by the principles of confidentiality. Personal information should be defined as information any person would consider to be private.

C. PRINCIPLES

~ Information can be shared in restricted circumstances

Even in restricted circumstances, information can only be shared on a need to know basis.

This should be with people who are directly concerned and who are also bound by the rules of confidentiality.

~ Information can be shared when it indicates that the person or other individuals are at risk of serious harm

It is necessary to disclose information concerning abuse. This would include instances when the person was engaging in or contemplating serious self-harm.

~ Information can be shared when a court has issued an order compelling disclosure

Courts of Law have the power to compel provision of information.

~ Information can be shared when it is required to ensure that the person receives the necessary care and support - not to share this knowledge would affect their service

Staff/Volunteers working alongside a person need to have sufficient information to enable them to perform their support duties. Care plans and strategies which support the person need to be shared with others who are working directly with that person.

Agencies such as social services, health authorities, care standards commission, welfare benefits agencies and housing providers share statutory roles and require information to ensure that financial and support services are maintained.

~ Information can be shared when the person concerned has given consent

Efforts must be made to ensure that the person in consent is based on an informed and free choice. It is recognized that some people may not be able to give or express their opinion about consent or non-consent. In this case, a decision to share information should be based on a best interest principle and a reasonable assumption that if the person had the capacity, they would consent. The service policy on consent has guiding principle in this area

<u>These are the only circumstances in which information about a person can be shared.</u>

Categories of Controlled Drugs

ANALGESICS (can also be classed under depressants)

- *Drugs which have a painkilling effect*
  - Heroin
  - Morphine
  - Codeine
  - Methadone

STIMULANTS

- *Drugs which act on the central nervous system and increase brain activity*
  - Cocaine
  - Amphetamine
  - Ecstacy

DEPRESSANTS

- *Drugs which act on the central nervous system and slow down brain activity*
  - Alcohol
  - Tranquillisers
  - Barbiturates

HALLUCINOGENS

- *Drugs which act on the mind distorting the way users see and hear things*
  - Cannabis
  - LSD
  - Magic Mushrooms
  - Ketamine

VOLATILE SUBSTANCES (can also be classed under depressants)

- *Drugs categorized as inhalants that can be abused*
  - Glues
  - Gasses
  - Aerosols

Signs of Drug Use

Some signs to look for if you are concerned about a Guests misuse of substances of any kind.

We need to remember that drugs will produce a slightly different reaction in users - especially among those who have just started to use that particular substance.

Different drugs produce different effects, resulting in variations in outward indications. Some signs are specific to opiates and narcotics and distinct from those experienced with central nervous stimulants like cocaine or depressants such as alcohol.

These are particularly useful when we suspect a guest may have been dragged into the 'drugs culture' by other guests.

- Change in friends, or hanging around with a new group.
- Reclusive behaviour
- Unexplained absence
- Lying or stealing
- Involvement on the wrong side of the law. ~;
- Deteriorating relationships, especially with volunteers.
- Obvious intoxication, delirious, incoherent or unconscious
- Change in behaviour
- Change in appetite

Although any one of the above signs on their own may, not be enough to indicate a problem, but they do give us a good indication.

There are other signs and symptoms that relate more specifically to the mental and physiological effects of substance abuse.

An obvious sign of opiate and narcotic abuse are tracks of needle marks. Users who inject often cover their arms etc even in very hot weather.

Opiate and narcotic abusers experience an accelerated heart rate, constricted pinpoint pupils and a relaxed or euphoric state that may lead to a dangerous level of respiratory depression that could lead to coma or death

Other signs and symptoms of drug abuse are dilated pupils, restlessness, hyperactivity, euphoria, slurred speech, disabled co-ordination, decreased attention span and impaired judgement

INFORMATION ON THE MOST COMMONLY USED RECREATIONAL DRUGS

LSD or Acid (tabs, trips, blotters or microdots)

Acid is a powerful hallucinogenic drug that alters a user's perception of the real world

Acid can turn users into a gibbering, giggling wreck, make the world seem like a magical place, and in a sublime experience make things so much better than they are. They could even make a football team like Crystal Palace seem like Real Madrid.

During the course of a trip, the entire universe can turn wobbly, colours become more intense, everyday objects take on bizarre and sometimes wonderful new forms, and user's senses can become totally confused and distorted.

Usually coming in the form of small squares of paper or tiny pellets (costing £10 - £15 a hit), acid can take anything from 20 minutes -2 hours to take effect, with trips lasting up to 7 to 12 hours. There is no way of knowing how strong a tab is, or how it will affect the user.

Side effects - Users normally expect to make substantial fools of themselves after taking acid. They could bellow out loud at the sight of a teacup, converse with trees, talk complete gibberish for hours on end and annoy just about anyone within a 10 yard radius

Some people may experience flashbacks days, or even weeks after taking acid, where it can feel like they are reliving certain elements of their trip(s).

Health Risks - There are no known physical side effects associated with acid use, nor is there any evidence of brain damage. There are, however, big psychological risks especially for those with a history of mental health problems

People should avoid taking acid if they are already feeling depressed, as this could result in a bad trip. Users have been known to harm themselves under the influence of acid.

Detection periods - LSD/Acid can be detected in urine for up to 2/3 days at common levels.

The Law LSD/Acid is classified as Class A under the Misuse of Drugs Act.

Cocaine/Crack (charlie, C, snow, coke, toot, rocks, stones)

Cocaine used to be the drug of choice for rock stars and the rich, but price cuts and increased availability have resulted in a massive rise in usage amongst a far wider range of society. A gram will cost around £20/30 for a paper wrap, although this price will vary wildly depending on the purity of the contents. The drug is usually snorted.

Delivering a quick and euphoric high, a blast of top quality coke can make the user feel like they have just scored the winning run in the Ashes.

Confidence soars through the roof, the heart thumps like a rock and roll crescendo, while users feel that they are on top of the world. Such is the effect of the drug that even the Fried Chicken Shop in Stoke Newington feels like the best place in the world to be after a hefty nose full.

Unfortunately the hit does not last very long (around 20 - 30 minutes) and this encourages repeated (and wallet bashing) doses. Smoking Cocaine can give a user a stronger hit, but the effects can wear off in as little as 12 minutes.

Crack is made from cocaine, baking soda and water.

Usually smoked through a water pipe, it produces a rapid, ultra intense high which lasts for about 2 minutes, followed by a pleasurable buzz, which usually lasts around 20 minutes before a long low or crash.

Because the hit is so strong, some users get hooked on the sensation and end up blowing all of their cash trying to repeat the sensation, or overdosing

Crack has increased in popularity hugely in recent years, with both clubbers and professionals regularly taking the drug. (Figures from the British Crime Survey show that 5 in 20 men between the age of 19 and 24 have used crack - twice as many as 5 years ago)

Despite media claims to the contrary, addiction is rarely instant. Street prices vary wildly, but a rock of smoke able crack can cost between £10 - £20

Side effects - users may feel like a million dollars on Coke, but to those around them they may well appear as an arrogant, loud idiot with their incessant gibbering and insincere waffling

Health Risks - Users should avoid taking crack with other stimulants or with alcohol. They will generally feel pretty bad the next day, and should take things easy.

Regular cocaine use can screw up the nasal passages and cause long term damage.

Because it is an appetite suppressant, coke can make users vulnerable to malnutrition, and like all stimulants can lead to heart problems. Injecting cocaine rapidly destroys the skin tissues and can cause ulcers.

Long term use can result in a range of mental health conditions from mild depression to the extremes of cocaine psychosis with symptoms similar to schizophrenia.

Prolonged Crack consumption can lead to the need for larger and larger doses resulting in an enormous compulsive craving and complete psychological dependence on the drug.

A growing danger is "mixing the gravy" where cocaine and heroin are combined to make a "speedball".

The combined strength of such a potent mixture can lead to a very dangerous dual addiction.

Detection Periods - Cocaine can be detected in urine up to 3 days after use.

The Law - Cocaine is classified as a Class A drug under the misuse of drugs act.

A recent survey in London found traces of cocaine on 99% of bank notes in circulation!

Cannabis **(spliff, marijuana, ganja, weed, hash, skunk, blow, puff)**

Cannabis is a naturally occurring substance that can act as a relaxant and mild hallucinogenic

When smoked the effects are generally felt very quickly with users feel more relaxed, happy and generally laid back.

Strong cannabis can also lead to pointless giggling, loss of inhibitions and an enhanced appreciation of music and colours.

Marijuana has also been reported to ease the pain, nausea and vomiting in advanced stages of cancer, AIDS and other serious illnesses.

Like most drugs, the effects vary wildly from one person to another, with factors like where users are, who they are with, and their general state of mind influencing the experience.

Most cannabis is pretty mild, although recent varieties such as skunk, northern lights or purple haze can have a very strong - and sometimes hallucinogenic effect.

Cannabis can be smoked with or without tobacco, filtered through water, cooled or inhaled using all manner of drug paraphernalia, or simply eaten. If eaten it is hard to tell when it will take effect, especially if the user has eaten a Billy Bunter sized Vegeburger beforehand.

The physical effects of too much dope can result in bloodshot eyes, a dry mouth and sloth-like reflexes and some users feel anxious and paranoid after a heavy session.

Side effects - For many, smoking dope is as natural and everyday as having a mug of tea, and they find that the drug makes their lives a little less stressful without unduly affecting their judgement or abilities.

For others it can have quite the opposite effect, turning ordinary folk into unbearable, lazy, spaced out hippies. A night of industrial strength spliffing can turn a user into a giggling oaf who will burst into laughter at wholly unamusing incidents and find deep intellectual depth in an Amy Winehouse song.

Health Risks - Most of the health risks associated with cannabis are those linked with the tobacco it is smoked with

The acute toxidity of cannabis and cannabis and cannaboids is very low, no one has ever died as a direct result of recreational or medical use

However, in some people prolonged use of cannabis can lead to severe mental health problems such as schizophrenia, bi-polar disease or psychosis.

The Law - Cannabis is classified as a Class B Drug under the misuse of drugs act

Detection periods - Cannabis can be detected in urine for up to 30 days after use.

Cannabis is less harmful than other class B substances including amphetamines, barbiturates or codeine like compounds.

Heroin **(smack, skag, brown, h)**

Heroin is a powerful and addictive substance that can be sold in the form of a powder, pill or a liquid. Its growth in the UK over the past 15 years is of epidemic proportions, partly as the result of easier availability and cheaper prices.

There are an estimated 500,000 addicts in the UK

Heroin can be smoked with tobacco, heated on tin foil ("chasing the dragon"), snorted or injected, either just below the skins surface ("skin popping") or directly into a vein ("mainlining"). The vast majority of UK addicts inject the drug

Initially most users experience a sleepy, pleasant euphoria and total relief from stress and anxiety as the drug enters the system. This then makes way for a feeling of calm and relaxation.

Heroin is not instantly addictive, but with regular usage the body adjusts and tolerance sets in, until no pleasurable feelings are felt at all. By then the body needs the drug just to stay "normal", and keep off the pains of withdrawal.

Feeding this addiction can cost up to £100 a day. Many users become involved in crime or prostitution just to feed their habit.

The stark truth is that heroin addiction is a hard, ugly addiction for most people and on that has wrecked many, many lives- although it is important to remember that not all addicts fit the stereotype of a loser bumbling around in the gutter. There are some addicts who are able to hold down normal jobs and positions of responsibility.

Side effects - Heroin can turn people into mumbling introspective bores, unable to get a grip on what is going on around them. Female users may have interrupted periods. Heroin suppresses the appetite and dehydrates the body.

Someone withdrawing from an opiate habit ("clucking" or going "cold turkey") is going to have a very grim time. Hot and cold sweats, nausea, diarrhoea and confusion are accompanied by an intense craving to take the drug to make them feel well again

Heroin withdrawal is not physically dangerous but will certainly be very unpleasant.

Heath risks - Most of the dangers of heroin use come from using shared or dirty needles which can greatly increase the risk of the user contracting diseases such as hepatitis, septicaemia, HIV, gangrene, pneumonia as well as developing body sores or ulcers.

Overdosing can lead to death - There are also many instances of deaths from users buying heroin that is too pure, or cut with dangerous substances.

The Law - Heroin is classified as a Class A Drug under the misuse of drugs act.

Detection - Heroin can be detected in the urine for up to 2 days after use

Methadone **(Mixture, linctus, meth, physeptone)**

Methadone is an opioid (a synthetic opiate) that is used by the medical profession as a substitute drug for people addicted to other opiates (primarily Heroin)

Methadone was first marketed as an analgesic (painkiller) for the treatment of severe pain. It is still occasionally used for pain relief, although it is normally used as a substitute for Heroin.

It is usually available as a liquid which should be swallowed. Tablets and injectable ampoules are sometimes prescribed, and like many other medicines some of these drugs are diverted and become available illegally.

Effects - When it is prescribed to people addicted to other opiates (normally heroin) the guidelines for the dosage are that it should be enough to prevent physical withdrawal symptoms. When a Heroin user is given methadone it is not intended to give them a buzz, or get them high.

Physical changes - As an opioid, regular use of methadone causes physical dependency, after using it regularly - whether prescribed or not. Once use has stopped users will experience a withdrawal. The

physical changes due to the drug are similar to opiates- suppressed cough reflex, contracted pupils, drowsiness and constipation.

The Law - Methadone is controlled under the Misuse of Drugs Act as a Schedule 2 drug, that is a substance considered to have a medical therapeutic use, and legal to possess only if prescribed by a doctor, and then only if taken in accordance with the doctor's instructions

Methadone is classed as a Class A drug.

Speed **(whizz, billy, sulphate, grudge, dexys, blues, base)**

Speed is a stimulant that keeps users awake for hours and jumping around like a nutter!

Its effects are like an adrenaline rush - it makes a users heart go like the Flying Scotsman, they will be bursting with energy and able to dance all night. Speed can wake someone up who is exhausted, make them feel extremely confident and turn the quietest introvert into a gyrating John Travolta on the dance floor.

Generally coming in paper wraps or tablets which cost about £8 - £10, speed is snorted, dabbed or swallowed, speed kicks in pretty quickly and not long afterwards a users mouth will become drier than a bag of dry stuff that even enormous quantities of Carlsberg will refresh. A user will often grind their teeth, resulting in an unexpected and unpleasant exhibition of "gurning"

Appetites often disappear and quality speed will probably keep a user buzzing for up to six hours.

Prolonged speed use builds up tolerance quickly and a user will find themselves having to take more and more for the same hit. To make matters worse, speed is often cut or adulterated with all manner of dodgy substances. Tablets are made with large amounts of chalk in them. Some speed has been confiscated by the police with a purity as low as 2%. Most speed will be 5 -10% pure.

Side effects - Speed can turn people into breathtaking bores. If you are cornered by someone who has just taken speed, expect hours of tedium as they recall in great details dull anecdotes from their earlier life Users often get very emotional and will reassure complete strangers that they are their best mates for life.

Users often lose their inhibitions when drinking, and mixing speed with alcohol means that instead of nodding off after a few drinks the speed makes them keep going and lose their inhibitions and there is a chance that they may wake up the next morning with a stranger/horse/whatever in their bed the next morning

The next day will probably be a dreadful experience. They will feel tired and weak, and if they have really overdone it, depressed and even paranoid, sometimes even having hallucinations

Health risks - Having high blood pressure or a dodgy ticker when taking speed could be risky. Users should not mix speed with drugs like poppers, coke or E as this could send their hearts AWOL They should also avoid taking speed while they are taking anti depressants as this combination has been known to be fatal.

Speed should never be taken while pregnant - apart from the drug there is the danger of what it has been cut with.

Also look out for "base" which is a deluxe version of speed with more intensive positive and negative effects.

The Law - The majority of amphetamine substances come under Class B of the Misuse of Drugs Act, those prepared for injection come under Class A

Drug Overdose

CALL 999 IMMEDIATELY
- IT IS BETTER TO BE SAFE THAN SORRY

If the patient is still conscious

- ⇨ Stay with them
- ⇨ Convince them to vomit immediately
- ⇨ Ask what drugs they took
- ⇨ Monitor them to ensure that they do not choke on their own vomit
- ⇨ Keep them awake

If they are unconscious

- ⇨ Position them lying down on their stomach and turn their face to one side
- ⇨ If they vomit, make sure that their airway is clear. Use your fingers to remove obstructions.
- ⇨ Closely monitor their breathing and pulse. If either stops perform CPR immediately.

If they are having convulsions

- ⇨ Do not attempt to restrain them, but try to guide them away from hazards to prevent injury.

Collect anything that was involved in the drug use

- ⇨ Try to indentify the drug(s) that have been taken - collect pills, vomit, syringes, pill containers and anything else which you think may help the emergency services

Life Saving Procedures

CALL 999 IMMEDIATELY IT IS BETTER TO BE SAFE THAN SORRY

As a first aider the priorities when dealing with a casualty are always the same:

- ⇨ **A**irway
- ⇨ **B**reathing
- ⇨ **C**irculation.

An initial check of a casualty will establish your priorities. When dealing with an unconscious casualty you should open and maintain their **airway** as your first priority. If the airway should become obstructed, possibly by the tongue falling to the back of the throat, then the casualty will be unable to breathe and this will lead to death if untreated.

The Initial check

Danger

Are you or the casualty in any danger? If you have not already done so, make the situation safe and then assess the casualty.

Response

If the casualty appears unconscious check this by shouting

'*Can you hear me?*', '*Open your eyes*'
and gently shaking their shoulders.

If there is a **response**:

- ⇨ If there is no further danger, leave the casualty in the position found and summon help if needed.
- ⇨ Treat any condition found and monitor vital signs - level of response, pulse and breathing.
- ⇨ Continue monitoring the casualty either until help arrives or he recovers.

If there is **no response**:

- ⇨ Shout for **help.**
- ⇨ If possible, leave the casualty in the position found and open the airway.
- ⇨ If this is not possible, turn the casualty onto their back and open the airway.

Airway

Open the airway by placing one hand on the casualty's forehead and gently tilting the head back, then lift the chin using 2 fingers only.

This will move the casualty's tongue away from the back of the mouth.

Breathing

- ⇨ Look, listen and feel for **no more** than 10 seconds to see if the casualty is breathing normally.
- ⇨ Look to see if the chest is rising and falling. Listen for breathing.
- ⇨ Feel for breath against your cheek.

*If the casualty is **breathing normally** , place them in the recovery position.*

- ⇨ Check for other life-threatening conditions such as severe bleeding and treat as necessary.

If the casualty is not breathing normally or if you have any doubt whether breathing is normal begin CPR:

If the casualty is **breathing**, the simple procedure of placing the casualty in to *the recovery position* should ensure that the airway will remain clear of obstructions.

The Recovery position

An unconscious casualty who is breathing but has no other life- threatening conditions should be placed in the recovery position.

- ⇨ Turn casualty onto their side.
- ⇨ Lift chin forward in open airway position and adjust hand under the cheek as necessary.
- ⇨ Check casualty cannot roll forwards or backwards.
- ⇨ Monitor breathing and pulse continuously.
- ⇨ If injuries allow, turn the casualty to the other side after 30 minutes.

If the casualty is not breathing normally , commence CPR

If the casualty has stopped breathing you can assist them by performing a combination of ***chest** compressions* and rescue breaths. You breathe out enough oxygen to potentially keep the casualty alive until the emergency services arrive, the oxygen you breathe into the casualty will need to then be pumped around the body using chest compressions.

It is important to remember that in any life threatening situation the **emergency services** should be called as soon as breathing or absence of breathing has been identified.

CPR (Cardio-Pulmonary Resuscitation)

Without oxygen the brain cells will start to die within a few minutes, we can artificially breathe for and pump oxygen around the body by using a combination of chest compressions and rescue breaths, this is known as CPR.

Some circulation can be maintained by performing chest compressions. By pushing vertically down on the centre of the chest, you squeeze the heart between the chest and backbone; this forces the blood out of the heart and into the body tissues. When the pressure is released, the heart comes back to its normal shape and blood is sucked in, which is forced out by the next compression.

You breathe out enough oxygen to potentially keep the casualty alive until the emergency services arrive. This expired air can be forced into the casualty's lungs and air passages by performing rescue breaths.

In cases of sudden cardiac arrest the oxygen level in the blood will remain high for a few minutes so initially chest compressions will be more important than rescue breaths

Alcoholism

What is Alcoholism?

Alcoholism, also known as alcohol dependence, is a **disease** that includes the following 4 symptoms

CRAVING

LOSS OF CONTROL

PHYSICAL DEPENDANCE

LOSS OF CONTROL

CRAVING - A STRONG NEED OR URGE TO DRINK

LOSS OF CONTROL - NOT BEING ABLE TO STOP DRINKING ONCE DRINKING HAS BEGUN

PHYSICAL DEPENDENCE - WITHDRAWAL SYMPTOMS SUCH AS NAUSEA, SWEATING, SHAKINESS AND ANXIETY AFTER STOPPING DRINKING

TOLERANCE - THE NEED TO DRINK GREATER AMOUNTS OF ALCOHOL TO GET 'HIGH'

There are many symptoms related to drinking problems. Alcoholism is considered a progressive disease, meaning that the symptoms and effects of drinking alcohol become increasingly more severe over time.

Those who use alcohol may begin to show early signs of a problem, then progress to showing symptoms of alcohol abuse; if drinking continues, they may later show symptoms of alcoholism or alcohol dependence.

Early Signs of a Problem

Early signs of alcoholism include frequent intoxication, an established pattern of heavy drinking and drinking in dangerous situations, such as when driving. Other early signs of alcoholism include black-out drinking or a drastic change in manner while drinking, such as consistently becoming angry or violent

The main symptom of alcohol abuse occurs when someone continues to drink after their drinking reaches a level that causes recurrent problems. Continuing to drink after it causes someone to miss work, drive drunk, shirk responsibilities or get in trouble with the law is considered alcohol abuse.

Symptoms of Alcoholism

For someone who is alcoholic or alcohol dependent, the symptoms include all of those associated with alcohol abuse (above). But alcoholics also continue to drink in spite of all the problems it has caused in their lives.

When alcohol abuse reaches the alcohol dependence stage, the person also experiences at least three of seven other symptoms, including neglect of other activities, excessive use of alcohol, impaired control of

alcohol consumption, persistence of alcohol use, large amounts of time spent in alcohol-related activities, withdrawal symptoms and tolerance of alcohol.

Q: What is the difference between alcohol abuse and alcohol dependence?

A: Alcohol abuse is described as any "harmful use" of alcohol.

Department of Health research describes alcohol abusers as those who drink despite recurrent social, interpersonal, and legal problems as a result of alcohol use. Harmful use implies alcohol use that causes either physical or mental damage.

Those who are alcohol dependent meet all of the criteria of alcohol abuse, but the will also exhibit some or all of the following:

- Narrowing of the drinking repertoire (drinking only one brand or type of alcoholic beverage).
- Drink-seeking behaviour (only going to social events that will include drinking, or only hanging out with others who drink).
- Alcohol tolerance (having to drink increasing amounts to achieve previous effects).
- Withdrawal symptoms (getting physical symptoms after going a short period without drinking).
- Drinking to relieve or avoid withdrawal symptoms (such as drinking to stop the shakes or to "cure" a hangover).
- Subjective awareness of the compulsion to drink or craving for alcohol (whether they admit it to others or not).
- A return to drinking after a period of abstinence (deciding to quit drinking and not being able to follow through).

Typically, those drinkers who are diagnosed as only alcohol abusers can be helped with a brief intervention, including education concerning the dangers of binge drinking and alcohol poisoning.

Those who have become alcohol dependent generally require outside help to stop drinking, which could include detoxification, medical treatment, counselling and/or self-help group support.

Words and Language related to Mental Health Issues and Services

Psychosis -	Thoughts and feelings that are considered to be out of touch with reality.
Organic psychoses -	Psychosis rooted in the physical impairment of the brain e.g. Alzheimer's. Difficulties in orientation, memory, learning and comprehension
Hallucinations -	Perceptions of things in the absence of external stimulus. Auditory, visual, tactile, olfactory, visceral.
Delusions -	A fixed, false belief (e.g. paranoid, grandiose, somatic, guilt)
Schizophrenia -	A diagnosis of a psychotic illness, characterised by delusions, hallucinations, thought disorder.
Major Tranquillisers -	Medication to treat and suppress symptoms of psychosis.
Depot Injection -	A slow release injection of a major tranquilliser.
Bi-polar Disorder -	A psychotic disorder characterised by severe mood swings (formerly known as manic-depression).
Neurosis -	A range of states characterised by high levels of anxiety.
Panic Attack -	A state of extreme anxiety, characterised by shortness of breath, racing pulse, fear of dying.
Phobia -	An extreme fear characterised by anxiety and avoidance.
Obsessive - compulsive -	Thoughts, ideas, or impulses that recurrently enter consciousness and behaviours that are repeatedly carried out in relation to the thoughts.
Minor tranquilliser -	Medication to reduce anxiety.
Dual Diagnosis -	Presence of a diagnosis of mental illness and substance abuse.

Mental Health Diagnosis – A quick guide

Psychoses

Psychoses are characterised by a different sense of reality.

1. **Schizophrenia**-

Symptoms include:

- Thought disorder (broadcast, insertion, chaotic)
- Withdrawal/ loss of drive/volition.
- Delusions
- Hallucinations

2. **Bipolar** – (formerly known as manic depression)

Symptoms include:

- Severe fluctuating mood, short or long term
- High energy and activity
- Very ambitious or grandiose ideas, flight of ideas
- Periods of severe depression

3. **Organic Psychoses** –

- characterised bv difficulties in orientation, memory, comprehension, learning.

4. **Dementias** eg. Alzheimer's

5. **Korsakov's psychosis** (results from chronic alcohol abuse)

6. **Wenicke's encephalopathy** (acute onset of Korsakov's)

Other Psychoses.

- **Alcohol induced psychosis**
- **Drug –induced psychosis**

Neuroses-

Neuroses are characterised by problematic levels of, and reactions to, anxiety.

1. **Anxiety states**
   - Symptoms include high levels of disabling anxiety.
2. **Depression, with high levels of anxiety.**
3. **Phobia**
   - Symptoms include experience of panic attacks, avoidance of feared object or situation.
4. **Obsessive-Compulsive Disorder**
   - Symptoms include unwanted, obsessive thoughts and repetitive, compulsive behaviours.

Personality Disorders.

Characterised by deeply engrained maladaptive patterns of behaviour. There are 10 defined personality disorders including; paranoid, schizoid, affective, borderline, sociopathic

Other diagnoses:

Eating Disorders.

1. **Anorexia Nervosa**
   - People with anorexia nervosa usually view themselves as overweight, even though they may be dangerously thin. Anorexia nervosa is a serious, often chronic, eating disorder.
2. **Bulimia**
   - Bulimia nervosa is a serious eating disorder, in which people binge eat, and later purge - either by vomiting, laxatives, excessive exercise

Post -Traumatic Stress Disorder

Post-traumatic stress disorder (PTSD) can be an extremely debilitating condition that can occur after exposure to a terrifying event or ordeal in which grave physical harm occurred or was threatened.