The Drug Treatment Outcomes Research Study (DTORS): Qualitative Study

Matt Barnard Stephen Webster and William O'Connor with Jones, A. and Donmall, M.

The qualitative study of the Drug Treatment Outcomes Research Study (DTORS) was designed to explore treatment providers' and treatment seekers' perspectives on the factors influencing the effectiveness of drug misuse treatment in England. The main implications of the research are as follows.

- The findings highlight the complexity of drug treatment and are suggestive of the need for drug treatment to be sufficiently flexible to enable consideration of the range of pressures reinforcing an individual's dependency and thus their differing needs from drug treatment.

- A key challenge in meeting the multiple needs of treatment seekers within a multi-agency model of delivering services is developing effective working relationships among provider partners. It was suggested by some practitioners that more needs to be done in some areas to develop and strengthen the links between provider organisations. This may have particular relevance to the reintegration agenda, and is to some extent a focus for some of the areas involved in the Drug System Change Pilots.

- The additional challenges of responding comprehensively to clients' needs against a backdrop of increasing numbers and longer retention in treatment were acknowledged.

- Service providers recognised a range of positive and negative impacts from the increase in referrals through criminal-justice-system routes. The benefits were felt to include increasing the numbers in treatment of people who would otherwise not have accessed drug treatment; the negative impacts were felt to include treatment services being under-resourced to cope with the additional high volume of clients.

- There was a widely held scepticism that treatment could be effective in the absence of a deep level of motivation on the part of the treatment seeker. Referral through the CJS did not seem to impact on levels of motivation. Thus both CJS and non-CJS pathways into treatment seem valid in this respect.

- Study participants reported that maintaining full and timely engagement with treatment seekers, particularly at key transition points such as leaving prison, was essential to successful drug treatment.

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Context

- This report describes the findings from the qualitative study of the Drug Treatment Outcomes Research Study (DTORS). It was designed to update existing knowledge on the effectiveness of drug misuse treatment in England within the context of changing patterns of drug use and an expansion in criminal justice referrals using stakeholder and client perspectives.

Approach

- The aims and objectives of the study were to use the perspectives of treatment providers and treatment seekers to provide an in-depth description of: the treatment needs of treatment seekers; the range of outcomes of contact with treatment services; and factors affecting the success of treatment.

- The qualitative study used in-depth unstructured interviews to explore the views and experiences of providers and treatment seekers of Tier 3 and Tier 4 drug treatment services, which offer structured interventions to people with significant drug problems.

- A sample of 32 front-line drug treatment providers were interviewed across four Drug Action Teams (DATs). The DATs were chosen so that there would be variation in relation to the number of people joining treatment programmes and the organisational conditions within which the DAT functioned. Treatment workers came from a range of modalities including prescribing services, structured day care, drug intervention programmes and residential rehabilitation services.

- A sample of 44 treatment seekers were interviewed across six DATs drawn from participants who completed the second wave of interviews in the quantitative element of the DTORS study as this maximised the number of potential participants (Jones *et al.*, 2009). Treatment seekers were sampled to reflect a range of experiences and backgrounds.

Findings

Treatment needs

- The needs of treatment seekers in this research were seen as reflecting the set of pressures directly reinforcing their drug-taking behaviour. These pressures were: drug-taking rewards; physical need; cognitive dependence; the impacts of dependence; and underlying vulnerabilities.

Motivation to change

- Some treatment providers and treatment users made the distinction between motivation that was just at the surface level and a 'deep' level of motivation. It was reported that 'surface'-level motivation could lead to positive short-term impacts but was seen as unlikely to lead to longer-term recovery.

- Referral to treatment via the criminal justice system (CJS) did not seem to affect treatment seekers' motivation positively or negatively.

Capacity for recovering from addiction

- Some treatment seekers with considerable issues, such as childhood trauma, seemed able to address their dependence with limited input from service providers. Conversely, some people with fewer issues and who received much more help showed little change in their drug use. This indicated that treatment seekers had varying capacity to address their own problems or respond to help or treatment.

Impact of personal and local environment

- The context in which treatment was taking place was seen as being able to either help or hinder change. Key factors included the level of drug taking in a participant's immediate environment; the presence of stressors in their life (particularly their housing situation); the presence or lack of a support network; and the attitude and approach of non-specialist services.

Response of service providers

- The importance of key workers building trust with clients was emphasised by both treatment providers and treatment seekers.

- Barriers to engagement with treatment services identified by treatment seekers included waiting times and difficulties in maintaining engagement at transition points, such as leaving prison.

- Barriers to assessment identified by treatment seekers included providers making inaccurate assumptions about the reasons behind their drug taking making them feel that the treatment being recommended was not appropriate.

- Barriers to referral described by some service providers included a reluctance to refer clients between treatment services because of fear of loss of funding, and reports from some treatment providers that other services, such as mental health, did not want to accept clients while they were still using drugs.

- Barriers to delivery described included service instability, high case loads, lack of training, and inexpert or insensitive delivery of interventions. Problems with a lack of aftercare in some cases and negative attitudes among some service providers were also identified.

- The range of positive and negative impacts from the increase in referrals through criminal-justice-system routes was recognised by service providers. The benefits were felt to include increasing the numbers in treatment of people who would otherwise not have accessed drug treatment; the negative impacts were felt to include treatment services being under-resourced to cope with the additional high volume of clients.

Outcomes of contact with treatment providers

- Five categories of outcome were constructed based on the accounts of treatment seekers. These were: recovering, stalled progress, illicit substance replaced, relapsed and no change in original behaviour.

Implications

- The findings highlight the complexity of drug treatment and are suggestive of the need for drug treatment to be sufficiently flexible to enable consideration of the range of pressures reinforcing an individual's dependency.

- A deep level of motivation on the part of the treatment-seeker was key to successful drug treatment.

- A current challenge to service providers was responding comprehensively to clients' needs against a backdrop of increasing numbers and longer retention in drug treatment.

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1. Introduction and background

Context

The Drug Treatment Outcomes Research Study (DTORS) is a major national evaluation of drug misuse treatment in England. A previous study (the National Treatment Outcomes Research Study – NTORS), undertaken during the mid-1990s, described the effectiveness of treating problem drug users. However, in the subsequent decade there have been fundamental changes in the delivery of drug misuse treatment in England and changes in the population receiving treatment.

DTORS was commissioned in order to refresh and refine the evidence base on treatment effectiveness. The study comprised a survey of 1,796 treatment seekers who had presented for a new episode of drug treatment, with follow-up surveys at between three to five months and again at around 12 months (Jones *et al.*, 2007; Jones *et al.*, 2009); an economic analysis of the costs and benefits associated with drug treatment (Davies *et al.*, 2009) and a qualitative assessment of drug treatment. This report presents the findings of the qualitative study which involved interviews with people who sought structured community-based or residential treatment (Tier 3 or 4)[1] drug treatment between February 2006 and March 2007 sampled from the DTORS wave 2 survey, along with interviews with a sample of treatment providers of Tier 3 and 4 drug treatment services. The interviews with treatment seekers were conducted between February 2007 and September 2007, which was between six months and a year after the start of treatment. The interviews with treatment providers were conducted between September 2006 and May 2007. The study aimed to answer the following questions:

- What are the drug treatment needs of treatment seekers?

- What are the factors that impact on the response of treatment service providers?

- What are the factors affecting the effectiveness of treatment, and how?

Background

The Drug Treatment Outcomes Research Study (DTORS) is a major national evaluation of drug treatment in England. A previous study (the National Treatment Outcomes Research Study – NTORS) described the effectiveness of treating problem drug users between 1995 and 2000. However, in the subsequent decade there have been fundamental changes in the delivery of drug treatment in England and changes in the population receiving treatment.

Drug treatment and rehabilitation services are commissioned and provided in four tiers. Tiers 1 and 2 provide open access and non-structured drug treatment services; information, advice and harm-reduction services; screening for drug misuse; and referral to specialist drugs services. Tier 3 provides structured community-based drug treatment and rehabilitation services. Services in Tier 4 provide residential drug treatment and rehabilitation, aimed at individuals with a high level of presenting need. Tier 3 and 4 services account for around 70 per cent of total drug treatment costs.

Over the last ten years, the use of crack or cocaine nationally has risen from approximately 14 per cent of drug users at the time of the NTORS (in 1996) (Department of Health, 1998) to 44 per cent in 2006 (NDTMS, unpublished), and up to 73 per cent in individual Drug Action Teams (DATs). Treatment

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1 Tier 3 treatment is community-based treatment involving regular sessions undertaken as part of a care plan, and includes prescribing, structured day programmes and structured psycho-social interventions. Tier 4 treatment is residential drug treatment, and includes in-patient treatment and residential rehabilitation.

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response for crack and cocaine users is varied and uncertain (Seivewright *et al.*, 2000; Gossop *et al.*, 2002). Concurrently, increasing use of referral schemes in the criminal justice system (CJS) has increased the proportion of drug-misusing offenders seeking treatment. Offenders who misuse drugs have been found to have more serious drug problems, which are potentially less responsive to treatment (Oerton *et al.*, 2003, Millar *et al.*, 2002; Sondhi *et al.*, 2002, Stewart *et al.*, 2000).

With substantial expenditure on drug treatment services, increases in the number and heterogeneity of drug users in contact with treatment facilities, and changes in the treatment process, new evidence is needed about whether services are effective and an efficient use of resources.

Aims and objectives

The primary aim of the qualitative study was to explore the factors affecting the outcomes of drug treatment from the perspective of treatment providers and treatment seekers. Specifically, the objectives of the study were to:

- explore the treatment needs of treatment seekers;

- identify factors affecting the response of treatment providers;

- identify factors affecting the success of treatment; and

- describe the range of outcomes of contact with treatment services.

Methodology

This qualitative study used unstructured interviews to explore the views and experiences of drug treatment service providers and drug treatment seekers. The findings reflect the range and diversity of drug treatment, and so this research will give a good sense of the variety of experiences that are present in the wider population. However, as is the case with all qualitative research, the numbers of participants expressing particular views or exhibiting particular behaviours is not reported as this has no statistical significance and no conclusions about the wider population can be drawn.

Sample
Purposive sampling (Ritchie and Lewis, 2003) was used in order to capture a diverse range of views from the population of interest.

Service-provider sample
Based on the number of clients seen at triage,[2] the percentage of CJS referrals and the size of the geographic area they covered, four Drug Action Team (DATs) areas of different sizes were selected. Within each of these a range of service providers were selected that delivered different types of treatment, such as substitute prescribing and structured day care. Finally, between one and three front-line drug treatment workers were selected from each treatment service.

A total of 32 drug treatment workers were interviewed across the four DATs, with some DATs accounting for more than others as not all types of treatment were present in each area..

Treatment-seeker sample
The sample of treatment seekers was drawn from participants who completed the second wave of interviews in the DTORS quantitative study, as this provided data to be used for sampling and maximised the size of the potential pool of participants (Jones *et al.*, 2008). Treatment seekers were sampled to reflect a range of experiences of treatment outcomes, their previous treatment history, their age and gender. Referral route was also used as a sample criterion, and it included both criminal-justice and non-criminal-justice routes. For criminal justice system referrals, the sample included those who were the subject of a Drug Rehabilitation Requirement (DRR) or other restriction on bail and those for whom attendance at treatment had no legal consequences i.e. voluntary diversion. Other sampling criteria, including marital status, ethnicity, number of drugs taken in the last year and the type of treatment received, were monitored.

In all, 44 treatment seekers were interviewed across six DATs (including the four DATs in the service provider sample and including 13 treatment seekers who accessed treatment through the criminal-justice-system). Table 1 describes the main treatment-seeker sample characteristics (see Appendix A for a more detailed breakdown of the achieved sample).

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2   Triage is the initial brief assessment of need that is undertaken when a treatment seeker first makes contact with a treatment service.

Table 1:   *Sample of treatment seekers by key characteristics*

Primary sampling criteria		Male	Female
Treatment status	In treatment	23	10
	Dropped out	7	2
	Completed treatment	0	1
Age group	18 – 29	18	7
	30+	14	5
Previous treatment history	None	8	3
	1 – 4 episodes	16	6
	>=5 episodes	8	3

Data collection

Interviews with treatment providers were conducted using topic guides and organised around the following key themes: personal background; the context of treatment; inter-agency working; the referral process; the treatment process; barriers and facilitators to successful treatment; and perceptions of individual role. The themes explored with treatment seekers were: personal background; present circumstances; drug use profile; overview of treatment career; current treatment; and treatment effectiveness. (See Appendix B for topic guides).

Analysis

Data were managed using the Framework approach developed by the National Centre for Social Research (Ritchie and Lewis, 2003). This involves summarising verbatim transcripts into a matrix organised by themes and sub-themes as well as by individual cases. The managed data were then interpreted with the aim of identifying and categorising the range of phenomena present in the study population. (See appendix C for a more detailed description of the Framework approach.)

Structure of the report

The rest of this report focuses on the range of factors that were perceived to have a bearing on treatment outcomes. **Chapter 2** discusses the treatment needs of those contacting treatment services. **Chapter 3** sets out factors related to treatment seekers and their environment that influence the effectiveness of treatment, while **Chapter 4** focuses on a range of factors that influence the delivery of treatment services. **Chapter 5** presents five categories of outcomes from contact with treatment services, while **Chapter 6** discusses the implications of the study's findings.

2. Treatment seekers: needs from drug treatment

While the decision to use drugs was seen as a choice by treatment providers and treatment seekers, they recognised that it was a choice made in response to a range of pressures reinforcing drug-taking behaviour. The accounts of treatment seekers indicated that similar patterns of drug use could mask very different sets of pressures reinforcing use and very different treatment needs. This chapter illustrates the range of pressures reinforcing dependency, developed from the descriptions of treatment seekers and providers.

The range of issues faced by treatment seekers was not, in the main, associated with the kind of drug they were using. The discussion below therefore describes the experiences of treatment seekers across the full range of substance use, with the only variations in experience described by participants at the level of physical need (discussed further below). Similarly, the descriptions reflect the treatment needs of clients referred to service providers via all referral routes, including CJS and non-CJS referral routes.

It is important to note that the pressures reinforcing dependency discussed below were not experienced by all treatment seekers. However, there was a strong sense of a 'hierarchy' with pressures such as reward and physical need at the top and pressures such as underlying vulnerabilities at the bottom. The pressures at the top of the hierarchy tended to be experienced by most or even all treatment seekers; while the pressures at the bottom tended to be more difficult and complex to address. Many

of the pressures were seen as 'hidden' in that they were not necessarily apparent to treatment providers at the point of contact, and indeed in some cases the treatment seekers themselves were not aware of them until they had participated in treatment of some kind.

Reward

Two main types of reward from taking drugs were identified by treatment seekers. The first kind was the hedonistic effect of taking a drug, while the second was the relief drugs brought from problems, emotional distress or simply boredom, a feeling described as like being '*wrapped in cotton wool*'. In some cases the hedonistic reward was described as reducing with increased tolerance to the drug, leaving people 'chasing' the feeling they first had. In contrast, other treatment seekers reported the feeling of relief from distress as being maintained for long periods.

Other, less obvious rewards were also reported. These included an increase in confidence, either through a pharmacological effect or by making the user feel 'special' or 'tough' because of the cultural connotations of drug taking.

Physical need

The symptoms of withdrawal were reported by some treatment seekers as existing even when the drug had stopped having a hedonistic effect, leading people to a point where using drugs simply enabled them to 'feel normal'. There were vivid descriptions of the effects of withdrawal, and some people described feeling very frightened of repeating the experience. Others, however, talked about withdrawing on a number of occasions without medical assistance, sometimes as a 'tactic' to avoid being dependent in prison. This indicates that individuals varied in their ability to deal with the effects of withdrawal and/or the severity of the symptoms varied between individuals. The experience of users of different types of drugs varied here, with heroin users reporting more severe symptoms of physical withdrawal than cannabis or amphetamine users.

Cognitive dependence

Following on from physical need, the ongoing desire to take a drug after the physical symptoms of withdrawal had ended was seen as a greater barrier to recovery by some treatment seekers because it lasted longer and was harder to address.

The physical hurt is over and done within three days... but what you've got to do when you've got clean, you've then got to deal with the mental addiction and that's where people fuck up. Anybody can come off it for three days, trust me.

(Female heroin user)

People, places and objects associated with drug use were mentioned as triggering the desire to return to drug use.

Impact of dependence

Both providers and treatment seekers described three broad ways in which prolonged and dependent use of drugs affected people and reinforced drug-taking behaviour, which had the potential to lock individuals into a cycle of use. These are described below.

Psychological effects
Low self-esteem, shame and feelings of degradation were all reported as being associated with drug taking, in some cases leading to suicidal feelings or the more passive desire to 'not wake up' the next morning. Dependence was also experienced as stifling emotional development, with both providers and treatment seekers reporting that people who stopped taking drugs often felt and acted as if they were the same age emotionally as they were when they started taking drugs.

We believe that whatever age a person started taking drugs, that's the age they'll be when they come in [to the treatment centre].

(Male treatment worker at a residential rehabilitation centre)

Another effect of dependence was that drugs appeared to become a key coping mechanism in some cases. Treatment seekers described how their response to a wide range of difficulties, from relatively minor things such as unpaid bills to major life events such as the death of relatives, was to take drugs rather than address the problem, a cycle perceived to be exacerbated by a lack of emotional maturity or feelings of low self-esteem or depression.

Identity effects
Treatment seekers sometimes described the experience of drugs 'taking over' their lives. This meant that they began to describe their drug use and even their dependency as part of what defined them as a person. In some cases, treatment seekers described feeling that their 'drug' self was different to their 'non-drug' self, in terms of the way they acted and what they were prepared to do to pay for their drugs. This meant they had to 'lie' to themselves

about their life and behaviour in order to reconcile their conflicting selves, inhibiting the process of self-reflection that was required to recognise the effects their drug use was having on them.

As a drug addict I have got to lie constantly, not only to other people, to myself really.

(Male heroin user)

Practical and relationship effects
The significant amount of time and energy that some treatment seekers spent in obtaining and using drugs meant that their interpersonal relationships came under pressure. One effect of this was that friendship groups were described as narrowing and that non-drug-taking friends were replaced by drug-taking 'acquaintances', which made contact with drugs more difficult to avoid.

Underlying vulnerabilities

Underlying vulnerabilities were deeply ingrained pressures identified by a range of providers and treatment seekers as directly contributing to dependence. However, not all those dependent on drugs had such underlying vulnerabilities, nor of course does everyone with such vulnerabilities develop a drug dependency; rather, providers and treatment seekers directly linked these issues to dependency for some treatment seekers and felt that it was important for them to be addressed. Interestingly, some of the difficulties identified by treatment seekers were not at the most extreme end of behaviour, yet they were nevertheless seen as directly linked to their dependency. The vulnerabilities are grouped below into three categories.

Developmental disruption
There was a wide range of ways in which issues that affected treatment seekers as they were growing up were identified as having a direct impact on dependency.

- **Childhood problems**: these ranged from sexual and physical abuse by family members or strangers to witnessing domestic violence and family breakdown. These experiences were associated with low self-esteem, depression, and feelings of guilt, fear and panic.

Me mother generally bringing me down. … I remember Social Studies lessons … and [being told] there is this drug, there is that drug, and I remember saying I am going to do every bloody one of them … I remember thinking I'd love to be able to just escape out of myself.

(Male heroin user)

- **Detrimental parenting approaches**: both overly restrictive and overly permissive parenting styles were identified by some treatment seekers as contributing to dependence. Overly restrictive parenting was seen as leading to feelings of having 'missed out' on the chance to experiment and limiting the development of emotional coping mechanisms. An overly permissive upbringing was seen as undermining the development of a sense of self-responsibility.

- **Adolescent problems**: problems of insecurity and low self-esteem in adolescence, along with things such as bullying and feelings of failure, were identified by some treatment seekers as root causes of their initial drug taking and subsequent dependency.

Adult problems
In addition to difficulties in childhood, a range of challenges that people faced as adults were seen by both treatment seekers and treatment providers as leading to problems with drug use in some cases. There were two categories of issues.

- **Crisis**: difficulties, such as the end of significant relationships or children being taken into care, were identified by treatment seekers as underlying their dependence by leading to a desire to escape reality or by inducing a lack of self care.

- **Traumatic events**: events, such as the death of a child, abortion and rape, were seen as directly leading to dependence. Treatment seekers described reacting to these events by turning to drugs as a way of coping with the pain and distress of the event.

I … knocked a guy over who'd stepped out on to me car, and he died in hospital about a day later or something. So I think that in a way has triggered it all off. … I needed something to block that out of my mind.

(Male heroin user)

Inherent conditions
Some treatment seekers identified a pattern of impulsiveness, risk taking or desire for excitement in their own behaviour, which they felt differentiated them from their friends and contributed to their becoming dependent on drugs while others did not. There were also treatment seekers who discussed mental health issues, such as psychosis, autism and depression that pre-dated their drug use.

I've been taking antidepressants and my doctor, he's upped the dose a couple of times over the last three months. But before, I wasn't really coping mentally. I was having good patches and bad patches. I think that was due to the fact that I stopped using heroin. You can use methadone, but … heroin stops you feeling depressed.

(Male heroin user)

The range of factors reinforcing drug dependency set out in this chapter describes the plethora of pressures and underlying problems faced by the drug users in this study. Treatment seekers and providers alike felt that acknowledging and understanding these factors was essential to effective drug treatment.

3. Treatment seekers: factors influencing recovery

This chapter sets out the range of factors related to treatment seekers and their environment that were seen as having a bearing on the effectiveness of treatment, starting with the motivation of treatment seekers and going on to discuss personal capacity and the impact of the context in which they were attempting to address their drug use.

Motivation

Irrespective of factors such as the nature of people's treatment needs or the type of treatment they received, a key theme in the accounts of both providers and treatment seekers was that an appropriate level of motivation was a necessary foundation for the process of recovery. There was widespread scepticism about the possibility of long-term change in the absence of sufficient motivation.

If you're not determined to come off [drugs don't] even bother [getting] a script, mate, because I'm sorry, until you're ready to come off it, there's no point in anybody trying.

(Female heroin user)

Some treatment seekers drew a distinction between different levels of motivation. They said that it was possible to want to stop taking drugs, but still not be motivated at a 'deep' level. Without this more profound commitment,

they believed it was difficult, if not impossible, to stop taking drugs for a prolonged period.

I wanted to stop for … about a year or so anyway … it's just, it's quite a big step really … it just seemed one of the hardest things to actually do … I think it's sort of a mind set, deep down you've got to want to.

(Male heroin user)

The key to this deeper motivational shift was thought to be a profound change in the way individuals viewed themselves. Some treatment seekers' accounts included descriptions of how they started to see themselves as 'junkies' and 'out of control', and of realising their behaviour was incompatible with important elements of their identity. Participants also talked about how they became aware of the effect their behaviour was having on others, such as partners, children and family, and expressed a desire for 'normality'. All these elements indicated that they had gone through a process of self-reflection, and in some cases they spoke about this in a very direct way.

The only time you see yourself is when you look in a mirror and you tend to find junkies don't look in mirrors very much … But the medical I had [in prison made me realise] I was an absolute mess and I'd not actually thought of myself that way before, I always kind of thought I was all right.

(Male amphetamine user)

This contrasted with individuals whose motivation was perceived to remain at a 'surface' level. This kind of motivation was expressed in terms of external considerations rather than internal change, for example doing it for parents, or for their children, or even for their key worker.

I wasted so much money and funding by going in rehabs, wanting to do it for other people. Which is never enough. You need to do it for yourself.

(Male heroin user)

It was reported that in some cases, this 'surface-level' motivation led to honest and sincere attempts to give up drugs, though it was also linked to the hope of finding a 'quick fix' such as a detoxification programme or a 'cure' such as methadone, rather than to addressing any underlying problems. Nevertheless, attempts to change based on a surface-level motivation were reported in some cases as having positive short-term impacts in terms of temporary abstinence, reduction in drug use or changes to risk behaviours.

Motivational change

Based on the accounts of treatment seekers, three pathways that could lead to a deep-level motivation were identified. The first was as a response to a traumatic or significant event. A second route was the experience of hitting 'rock bottom'; in this case, it was not a particular event, but a feeling that drug use meant a treatment seeker had got to a position where they could not envisage being any lower. The final route was a feeling of having become 'sick' of the life of a drug addict. This was defined as a growing awareness of the monotony of the routine of acquiring and using drugs and the overall negative impact of drug use. Underlying these pathways was a sense that, firstly, an alternative life was possible and secondly, that it was meaningful, that is, there was some wider significance in stopping drug use.

There were contrasting views about whether it was possible for service providers to change treatment seekers' motivation. The treatment seekers interviewed as part of this study were consistent in saying that their contact with treatment services did not have any effect on their motivation and that they felt it was not possible for a provider to change it.

I don't think there was anything they could have said with me, I think I have to be ready myself.

(Male heroin user)

On the other hand, some providers described cases where they felt they had been able to affect the motivation of treatment seekers with positive results in terms of the client's engagement with treatment programmes.

Assessing motivation

It was challenging for providers to make an accurate assessment of treatment seekers' motivation to change in all cases. Some providers felt that treatment seekers turning up for their appointment was a good indication that they had a high level of motivation, while others believed that it was possible to pick up signs from the way clients discussed their lifestyle and from non-verbal clues such as body language. However, it was also recognised that these signs were not always reliable.

We don't always get it right because they are the best at manipulation, they're the best at saying what they think that they have to say in order to get a result, because that's the nature of the lifestyle that they've had before.

(Treatment worker, specialist addiction unit)

Impact of CJS referral on motivation

The accounts of treatment seekers indicated that referral through the criminal justice system seemed to have little positive or negative effect on the motivation of individual treatment seekers. This was the case whether the referral was voluntary or through a mandated route such as a Drug Rehabilitation Requirement (DRR) or other restriction on bail. Those who were motivated to address their drug use said they were pleased to have the opportunity to access treatment rather than go to prison.

Some treatment seekers and providers thought that some people who accessed drug treatment through the criminal justice system did not want to stop using drugs but only wanted to avoid jail. Some treatment seekers who had been referred through the CJS also thought that their contact with treatment services did not mean they became motivated to stop taking drugs. Nevertheless, some thought that even those whose contact with treatment services was the result of very short-term, pragmatic considerations said the time spent in treatment could have a positive impact.

I went so I didn't have to go to jail basically, I didn't treat it seriously. As soon as I'd done three months I phoned up my probation officer, I said will I get breached if I come out now? She said well no, we'll not breach you ... So I come out … and I did keep clean for over a year ...

(Male poly-drug user)

The self-capacity of treatment seekers

Alongside the impact of motivation on treatment outcomes, there were also participants who appeared to have significant needs but were able to recover with limited input from treatment providers. This seemed to reflect their own capacity for dealing with their problems. In some cases this was seen by providers as being linked to a greater degree of life skills.

There was evidence that some of the pressures reinforcing drug use reduced over time; some treatment seekers for instance, described a decrease in the pleasurable effects of drug use, and there were also descriptions of age-identity effects that counteracted some of the pressures to take drugs. These included perceptions of the ageing effects of drug taking, and the perceived age-appropriateness of taking drugs, along with a growing awareness of the nature of an individual's life in comparison to their contemporaries.

Seeing other people that are younger driving about in cars and stuff. And they're walking about with nice clothes on and that. Just little things. All adds up dunnit?

(Male heroin user)

Influence of personal and local context

Treatment seekers talked about the fact that their attempts to change their drug-taking behaviour occurred within diverse environments, and described some elements as helping the attempt and others as hindering it.

Support network

Some treatment seekers felt that being able to maintain close relationships with non-using partners, parents and friends was positive where it made the individual feel cared for and where it provided them with the opportunity to discuss their feelings and share problems. It was also felt that there was an additional benefit in maintaining relationships with a non-using network as friends or family members played a part in helping 'police' the recovery.

Me kids know this time, so it makes it a lot harder to go back because I've got them checking all the time.

(Female heroin user)

Support networks were also seen as positive where a significant person in a treatment seeker's life had successfully addressed their own drug use. This was seen as demonstrating that it was possible to stop using drugs and desirable to do so, and also as providing a non-drug-taking environment to socialise in.

However, some people described experiencing difficulties as a result of maintaining relationships with non-users. These included situations where a non-using partner could not comprehend the strength of the pressures reinforcing drug-taking behaviour, which was seen as being responsible for causing friction and additional stress. Another difficulty expressed by treatment seekers of maintaining contact with non-users was where individuals felt tied to a particular geographical area because of caring responsibilities or emotional links, which meant they remained exposed to a drug-taking environment.

Some treatment seekers in relationships with drug-using partners felt that, where both partners attempted to stop using drugs at the same time, the relationship could be seen as having positive feedback effects where partners could reinforce behaviours that supported them in not taking drugs and challenging behaviours that undermined success. On the other hand, there were negative effects

where a relapse on the part of one partner could influence the other partner to relapse as well.

Triggers to relapse

There were a number of aspects of the environment that treatment seekers identified as acting as stimulating the desire to take drugs again. Seeing drugs, drug paraphernalia or even people or places associated with drug taking were all described as triggering the craving for drugs.

You know, things as silly as road signs used to get me going. I would see a sign for somewhere [where I used to live] *and as soon as I saw that sign my stomach would turn.*

(Male heroin user)

Other stressors were identified by treatment seekers and providers as also disrupting attempts at change, with accommodation problems being considered as a major stressor in this respect.

Homelessness is a massive problem. Probably the biggest problem that mental health workers and drug workers in [this area] *have is in getting people into adequate housing.*

(Female drug worker in community drugs team)

Difficulties with accommodation were related to the availability of appropriate housing in the local area and to the approach of housing providers in prioritising individuals in treatment. Difficulties were also linked to a lack of temporary shelters.

Finally, weekends were identified by some treatment providers as periods when there was a particular danger of relapse. This was because they were often associated with a time for relaxation and enjoyment. It was also the time when treatment services and other support services were often closed.

Approach of non-specialist services

Services such as GPs, hospitals and housing services were identified as providing support as well as, or instead of, specialised services. However, a number of treatment seekers described experiences where negative attitudes or lack of understanding of dependence was felt to be a barrier to the provision of appropriate help.

The recommendation after the course was that I should see a psychiatrist because of my needle fixation and that I should get counselling and all that. I went to see my doctor when I first came out … and he kind of laughed at me and said what I needed was a kick up the arse.

(Male heroin user)

In other cases, the attitude or approach of some non-specialised services meant that some treatment seekers were unable to move forward in terms of getting stable housing or employment. This was described by treatment providers as having a negative effect on the self-esteem of treatment seekers and making them feel disillusioned, and was perceived as having a knock-on effect on their treatment.

The following case was described by a treatment provider as a way of illustrating the potential impact of negative attitudes of local service providers on the recovery of treatment seekers.

> ### Case study
>
> A male user who was sleeping rough and was very strongly motivated to address his drug use was doing well in treatment and began applying to housing services for accommodation. This was rejected because of his previous convictions and had the effect of undermining his motivation because he felt that he was making lots of changes but coming up against significant barriers. The effect was compounded by the fact that he was frequently being stopped and searched by police though he stated that he was no longer committing crime, which he found embarrassing. He relapsed and, although he is still in treatment, he has returned to the first phase of the treatment process. (Reported by treatment worker in structured day care)

4. Factors influencing the delivery of treatment

This chapter discusses the key factors as perceived by treatment seekers and providers as being most important in influencing the delivery of treatment. The role of key workers is described through the stages of service provision, namely: assessment, referral, and delivery. Finally, the chapter reports on the impact of Criminal-Justice-System referrals in influencing the delivery of drug treatment.

Role of key workers

Key workers were identified by treatment providers and treatment seekers as central to a successful outcome. In order to effectively carry out their role, both providers and treatment seekers believed that key workers needed to form a relationship with clients based on trust. Trust was felt to develop where workers demonstrated a non-judgemental attitude towards treatment seekers, demonstrated commitment to the relationship and showed that they cared about the welfare of the individual. Credibility was also emphasised by both treatment seekers and providers in giving the key worker permission to be challenging where appropriate.

Treatment seekers' accounts suggested three kinds of behaviour that were disruptive to the process of establishing trust: displaying a negative attitude towards clients; communicating in a way that demonstrated a lack of experience or understanding of the drug world; and talking in an overly formal or technical way without taking into account the realities of life as an addict. Some treatment seekers felt these behaviours were more often associated with workers who themselves had no personal experience of drugs or dependence. However, while some providers acknowledged the potential advantages of personal experience, this view was tempered by the belief that both those with and without personal experience could work effectively with treatment seekers.

Treatment seekers indicated that a relationship based on trust enabled key workers to fully assess their needs and therefore refer them to appropriate services and also to encourage and provide emotional support through the treatment journey. Treatment seekers also repeatedly referred to the role key workers played in directly addressing their needs through a combination of listening, empathising and offering advice and an alternative point of view. There were reports where relatively brief contact with skilled key workers had addressed very significant underlying vulnerabilities.

Engagement

Some examples were provided of difficulties with treatment seekers maintaining timely engagement due to waiting times for a range of services, including prescription, counselling and residential rehabilitation. This meant that individuals were unable to start the treatment process when they were ready to do so. In some cases, treatment seekers felt that some service providers seemed to be reluctant to engage with individuals and so they found themselves in a referral 'loop', constantly being passed on from one agency to another. This was judged to occur because of an apparent gap in services for people with specific support needs.

I think for seven years I have been in and out of seeing people, and referred to people and gone to these people and been told I can't be seen because my support needs are too high or too low and there is no medium. You kind of feel rejected in some way because where do you fit in?

(Male cocaine user)

An inadequate level of engagement undermined the belief that help was available for treatment seekers or that anyone cared about their situation. It also meant that they had to repeatedly relate their sometimes difficult history seemingly for no purpose, making them more reluctant to disclose their problems in the future. Transition points, such as leaving prison, were described as particularly challenging in terms of maintaining engagement.

Because funnily enough to keep me [methadone] I had to stay in prison for another three hours to see this woman and after you've been in prison for six weeks you don't wanna mess around for three hours.

(Male heroin user)

Assessment

Building on initial timely engagement, continuous engagement was stressed as an important feature of assessment. Although there would be a formal initial assessment process in all agencies, providers recognised that assessment needed to be a prolonged, dynamic process and therefore the first meeting did not always provide an opportunity for a full assessment.

A lot of people understandably don't want to bear their souls the first time they meet somebody. [Assessment] is something that goes on as the therapeutic relationship grows and as treatment continues and the trust builds.

(Female treatment worker, community drugs team)

As discussed earlier, in some cases treatment seekers did not necessarily have a good understanding of all the factors that influenced their dependency until after they had started treatment.

I'd say that [the accident] were main catalyst for why I got into it [drugs] in first place, but not even realising at time … It weren't until I had counselling over the last couple of years that I realised that.

(Male heroin user)

On the other hand, it was felt that difficulties also occurred when there was an assumption that there had to be major underlying vulnerabilities for all users or that specific events necessarily contributed to pressure

to take drugs. Where this did not match the perceptions of treatment seekers, it made them feel that they were not listened to and one outcome of this was that they disengaged with the treatment service.

One of the key workers was being really obnoxious and nasty with me so I came home after three days … he seemed to think that everybody in there who had a drug problem, it was the parents' fault … Well I didn't see it that way.

(Female heroin user)

Referral

One area of concern identified by some service providers related to a reluctance to refer clients because of fears of loss of funding. In part this was ascribed to the competitive environment in which agencies operated, though providers also identified individual attitudes and lack of training as influencing factors.

It was quite easy to see there was some politics and a preciousness about your clients, not wanting to refer clients between services because you might lose that client to that other service.

(Female treatment worker, specialist cocaine service)

Another area of concern was the relationship between drug treatment services and mental health services. Some service providers felt that some mental health services were reluctant to accept referrals from treatment services because they felt the client's drug problem needed to be addressed before the individual could be assessed or treated for a mental health problem. However, treatment providers believed this failed to take into account the role mental health issues played in reinforcing dependency.

The general view of the psychotherapy service is that that's not appropriate whilst the client is using drugs and the reason that will be given is that you can't reprocess things and realign your internal psychological blocks whilst you are using drugs … Our view is that's a bit chicken and egg. So we are at loggerheads and unfortunately there is no likelihood that that's going to change in the near future.

(Male treatment worker, specialist addiction unit)

This tension illustrates the importance of effective partnership working for effectively addressing all of a treatment seeker's need.

Delivery

A range of challenges to delivery were identified by service providers and treatment seekers. These were linked to limits in the capacity of treatment agencies and individual

treatment workers, the approach and ethos of treatment services, and the actual practice of treatment delivery. These are explored below.

Capacity

Where there was a high turnover of staff or a high sickness rate, service providers and treatment seekers said that the consistency of care given to treatment seekers could be compromised due to the impact on the worker-client relationship and the variable approaches of individual workers to addressing addiction.

You kind of get used to seeing one of them and then you've got to start all over again trying to prove yourself to them that you are getting clean.

(Male heroin user)

High case loads were a major concern of providers and were seen as undermining their ability to build a relationship with clients and to delivering appropriate interventions. There were some reports of methadone prescribing being encouraged because it was quick and relatively easy to do, but this not being backed up by efforts to address the underlying problems of treatment seekers.

In an ideal world it would be a handy spanner in your therapeutic tool box. In practice it becomes the focus of what we do [because of] the emphasis on the throughput … it's pretty much all you can do as other interventions take that much more time and attention.

(Treatment worker, community drugs team)

Compounding the problem of limited time was a feeling among some treatment workers that they were expected to implement complex psycho-social interventions without having had sufficient training.

Delivery of interventions

The accounts of service providers and service users provided some examples of interventions being implemented in insensitive or inexpert ways. One example was over-forceful challenging within group therapy contexts that was experienced as bullying.

The first group sessions … I asked not to speak and she wouldn't have none of it. So I just basically gave a brief introduction about myself and one guy said, how long have you been doing it for, I told him. He said to me, oh you don't need to be here, I have been doing crack for ten something years. They were like bullying me, I lost it, I was like well screw you, threw a chair and what not.

(Male poly-drug user)

Another example described by treatment seekers was of going into rapid detoxification units and having little or no contact with any support services when they left. This was seen as contributing to relapse.

Impact of CJS on provider response

The accounts of some treatment seekers indicated that referral through the criminal justice system (either through a Drug Rehabilitation Requirement (DRR) or other restriction on bail or those whose referral had no legal consequences) could have both positive and negative impacts on the services they received. It was positive where it facilitated access to better treatment than the individual had been getting or would otherwise have received. This was either because there were more services available through the CJS or because treatment seekers were put in contact with a service that was better able to address their needs than the services they were already in contact with. Providers of non-statutory services also spoke of the effectiveness of some Drug Intervention Programmes (DIPs) in assessing clients' needs and managing their treatment plan, enabling the non-statutory agency and the client to be clear about who was acting as the care-coordinator and who was providing a particular intervention. However, the fact that some CJS workers acted as both key workers and enforcers of the mandatory requirement to participate in treatment, undermined treatment seekers' trust in some cases and meant they were unwilling to discuss their problems openly. As with other providers, there were reports of some CJS workers displaying very negative attitudes towards treatment seekers.

There were examples where some DIP workers were not assessing need but instead basing their referrals on the preferences of clients or referring them to a prescription service by default. Some treatment providers felt that this practice appeared to be underpinned by DIP targets that were aimed at getting people into treatment and reducing offending rather than being focused on dealing with addiction.

There was also a concern that the different approaches to treatment could cause friction between CJS and non-CJS services. This was the case where CJS services were seen as focused on 'compliance' rather than reducing drug use. Some treatment providers also reported feeling uncomfortable in being part of a system that imposed penalties for not attending appointments, and believed it undermined the confidence of clients in their service, meaning they stopped accepting mandated CJS referrals.

We had one incident last year when someone was arrested on our doorstep who was in the project, which goes against all our ethos … It's meant to be a place where you walk in and you feel safe and secure.

(Treatment worker, structured day care)

In terms of organisations receiving CJS referrals, the increased volume of clients was seen by some as putting pressure on the organisations to move people through the system more quickly than they felt they should have been in order to create space. There were also difficulties reported in dealing with the increased volume of clients referred either through a Drug Rehabilitation Requirement (DRR) or other restriction on bail, some of whom treatment providers felt were not motivated to change.

A problem that we've got at the moment with DRRs, is that we have got … targets to meet. And so if we were to only accept the people that we thought were genuinely really motivated and up for it, we wouldn't come anywhere near the number of starts that we are expected to get. So you do sort of take people on and think, I'm not too sure about this person but we'll see how we go.

(Treatment worker, structured day care)

In some cases, the difficulties these clients caused was related simply to a lack of engagement in particular therapeutic interventions, but in others clients were reported as actively disrupting the treatment process, affecting the treatment received by other users of the service.

5. Outcomes of contact with treatment services

This chapter describes the range of outcomes reported by treatment seekers throughout this study. It demonstrates how the factors discussed in the previous chapters – the needs, motivation and capacity of treatment seekers, the personal and local context of treatment and the response of providers – all interact with, and contribute to, the different treatment outcomes. The categories have been constructed based on the accounts of treatment seekers, reflecting their reports on the nature of their drug use, their state of mind and their ability to move forward in their lives. These categories are based on the accounts provided through the course of this research, which has included a range and diversity of experiences, and so give

a good sense of the variety of outcomes that are present in the wider population, However, the categories in this chapter are dynamic and as such, not all treatment seekers will necessarily fit exclusively into any one of the groups.

Outcomes of treatment services

Type 1: Recovering
Characteristics – treatment seekers in this category were no longer using illicit drugs, or were using a minimal amount and felt it was no longer a problem. While they may have been using a prescribed drug as an aid, it was not the critical factor in their resilience to taking drugs. Any use of other illicit drugs was limited and did not impinge on other activities or relationships. They had a broadly positive mental state and were able to think about and make realistic plans for the future. They may have had occasional lapses but these did not lead to a full-blown return to uncontrolled use. They wanted to stay off drugs and had the sense of stability to feel that was achievable. They were not committing crime, were building positive interpersonal relationships and taking positive steps in terms of education and employment.

Explanation – treatment seekers in this category were characterised either by feeling that their needs were being met by treatment, or that they had sufficient motivation and capacity to address the pressures reinforcing addiction without the help of treatment. Where they felt their needs had been met, this could either be because they had high needs and received a lot of help or that they received a limited amount of help but had low needs.

Type 2: Stalled
Characteristics – treatment seekers in this category were also no longer using a significant amount of illicit drugs, but felt unable to move forward and get on with their lives. For opiate users their prescribed drug use was a critical factor in their resilience, and in some cases they were using other illicit drugs. Generally, they had a poor mental state, and, for example, found it hard to think about and make plans about the future. Some were committed to staying off drugs, while others were ambivalent, but in both cases there were doubts about whether it was achievable. Treatment seekers in this category tended to describe their interpersonal relationships as poor and they reported making few, if any, positive steps in terms of education and employment.

Explanation – some participants in this group were felt to be motivated and had reduced or stopped their use of drugs, but had not addressed the full range of pressures

reinforcing their use and therefore had not continued the process of recovery. There were also treatment seekers in this category who were committed to change, but were unable to initiate or maintain the process of recovery. This was because either there were felt to be too many pressures in their life, or because they were unable to get the help they needed from treatment services.

Type 3: Substance Replaced

Characteristics – treatment seekers in this category were no longer using the illicit drug they entered treatment for (or had significantly reduced their use), but had replaced it with an alternative drug. They tended to have a poor mental state, and so found it hard to think about and make plans for the future. Their interpersonal relationships were mostly described as poor and they were taking limited if any steps in terms of their education and employment needs.

Explanation – it was felt that the motivation of individuals in this group to stop using drugs was focused on a particular drug but not in ceasing to use drugs problematically altogether. The result was that they strategically replaced one drug for another and did not attempt to address the range of pressures reinforcing their use.

Type 4: Relapsed

Characteristics – treatment seekers in this category had started using a significant amount of an illicit drug again having experienced a significant period of abstinence or highly limited use. They had a sense of failure and guilt and found it difficult to visualise the future. They had a strong desire to stop using again, but had doubts about their ability to do so. Their interpersonal relationships, along with their education and employment situation, were suffering.

Explanation – people in this group were committed to change and had begun the process of recovery but the process had broken down. This was because either they had not dealt with all the pressures reinforcing their drug use or because of an increase in the pressures or stresses at a point when recovery was not well enough established.

Type 5: No Change

Characteristics – participants in this category had experienced little change in their pattern of drug use after contact with treatment agencies. They had an unpredictable mental state, reflecting their current drug use and circumstances, and a similarly unpredictable ability to think about and make plans for the future. They had a negative or ambivalent attitude to drug use, but felt unable or unwilling to stop their use, and in some cases they were committing crime. Their interpersonal relationships tended to be poor and they were taking limited, if any, steps in terms of education and employment.

Explanation – the reasons why people ended up in this category were difficult to explore fully because participants were often under the influence of drugs during the interview. However, again individuals in this category seem to be divided into two groups: those who were motivated but had not been able to start the process of recovery and those who were not and so did not engage in the process.

6. Implications

The qualitative study of the Drug Treatment Outcomes Research Study (DTORS) was designed to explore treatment providers' and treatment seekers' perspectives on the factors influencing the effectiveness of drug misuse treatment in England. The main implications of the research are as follows.

- The findings are suggestive of the need for drug treatment to be sufficiently flexible to enable consideration of the range of pressures reinforcing an individual's dependency and thus their differing needs from drug treatment.

- A key challenge in meeting the multiple needs of treatment seekers within a multi-agency model of delivering services is developing effective working relationships among provider partners. It was suggested by some practitioners that more needs to be done in some areas to develop and strengthen the links between provider organisations.

- The additional challenges of responding comprehensively to clients' needs against a backdrop of increasing numbers and longer retention in treatment were acknowledged.

- Service providers recognised a range of positive and negative impacts from the increase in referrals through criminal-justice-system routes. The benefits were felt to include increasing the numbers in treatment of people who would otherwise not have accessed drug treatment; the negative impacts were felt to include treatment services being under-resourced to cope with the additional high volume of clients.

- There was a widely held scepticism that treatment could be effective in the absence of a deep level of motivation on the part of the treatment seeker. Treatment seekers referred through the CJS did not report that the process had affected their levels of motivation positively or negatively. Thus both CJS and non-CJS pathways into treatment seem valid in this respect.

- Study participants reported that maintaining full and timely engagement with treatment seekers, particularly at key transition points such as leaving prison, was essential to successful drug treatment.

Appendix 1   Sampling

Purposive sampling (Ritchie and Lewis, 2003) was used in order to capture a diverse range of views from the population of interest. Within this approach, the rationale in selecting people to participate was not to select a sample that was statistically representative of all service providers or treatment seekers, but to ensure diversity of coverage across certain key variables (these are contained in the body of the report and a more detailed breakdown for treatment seekers is included below). The aim of the strategy was to ensure that the full range of factors, influences, views and experiences associated with the treatment of users of Tier 3 and Tier 4 services could be explored.

Using a sample that is not statistically representative of all service providers or treatment seekers means that it is not possible to generalise the findings of the study. Therefore, the number of treatment seekers and treatment providers who described particular experiences or held particular views cannot be estimated based on the data in this report. However, as we were able to achieve a sample

of respondents with a broad range of experiences and in a wide variety of circumstances, this study does give a good indication of the range and diversity of the views and experiences of the study population across the key dimensions of relevance to drug treatment in England.

Table A2:   ***Number of treatment-seeker interviews per DAT***

Interviews per DAT	Achieved
Large	13
Medium	5
Small–medium	5
Small	6
Additional DAT 1	10
Additional DAT 2	5
Total	**44**

Two additional DATs were used because there were not enough potential participants in the four original DATs.

Table A3:   ***Treatment-seeker primary sampling criteria***

Primary sampling criteria		Male achieved	Female achieved
Treatment status	In treatment	24	10
	Dropped out	7	2
	Completed treatment		1
Age group	18 – 29	18	7
	30+	14	5
Previous treatment history	None	8	3
	1 – 4 Doses	16	6
	>=5 Doses	8	3

Table A1:   ***Sample of treatment providers by treatment type and DAT***

Area	Community Drug Team	Structured day care	Drugs Intervention Programme	Residential rehabilitation	Shared care	Specialist addiction unit
Large	2	3	/	4	1	/
Medium	1	4	2	/	/	1
Small–medium	2	1	3	/	1	/
Small	2	2	2	/	1	/
Total	**7**	**10**	**7**	**4**	**3**	**1**

Table A4:   **Treatment-seeker secondary sampling criteria**

Secondary sampling criteria		Number of interviews
Referral route	Non-CJS	31
	CJS	13
Drugs taken in last year	0 – 4	18
	5+	26
Treatment received	In-patient detox	1
	Substitute prescribing from a drug team doctor	24
	Substitute prescribing from a GP	2
	Counselling	20
	Daycare/structured day programmes	6
	Residential rehab	4
	None	8

Appendix 2   Topic guides

As this was an exploratory study, participants were encouraged to discuss their views and experiences in an open way without excluding issues which may have been of importance to individual respondents and the study as a whole. Therefore, the questioning was responsive to respondents' own experiences, attitudes and circumstances. Topic guides were used to identify the key themes that were likely to be relevant in the interviews and to help ensure a systematic approach across the different encounters without restricting the range of questions that were asked. The order in which issues were addressed and the amount of time spent on different themes varied according to individual demographics, roles, experiences and the dynamic of the interviews.

The topic guides used for interviews with service providers and treatment seekers are set out below.

Service-providers' topic guide

1.   Introduction

Aim: To introduce the discussion and NatCen.

- Introduce self, NatCen
- Introduce research: see above
- Explain: confidentiality, tape recording, length (about an hour and a half) and nature of discussion (specific topics to address, but conversational in style), reporting and data storage issues
- Any questions

2.   Participant background

Aim: To introduce participant and set the context for proceeding discussion.

- Current position/job title
- Time in current position
- Pathway into current position
- Roles and responsibilities within the treatment centre (support/mentoring/clinical supervision)
- Level of personal contact with clients
  - Caseload
- Training and education for this role (probe personal experiences, only if raised first by the participant)

3.   Social/ local context of treatment

Aim: To place the treatment programme and the client base into local context, exploring local market, and client needs.

- Overview of the local drug market
  - Main drug of choice in area
  - Market for drug in area

Probe: difference by client age, gender, background, ethnicity, locality, injecting practices, combinations of drugs used, any recent changes.

- Nature of community in treatment
  - Range of issues faced by clients

Probe: drug issues, employment issues, housing issues, relationship/family issues, offending issues, friendship/peer issues.

- ○ Representation of minorities (barriers/facilitators to participation in programme)
- ○ Representation of women (barriers/ facilitators to participation in programme)
- ○ Representation of offenders (barriers/facilitators to participation in programme)
- Impact of urban/rural location
- Funding of respondent's organisation
  - ○ Effect on interventions offered
- Targets
  - ○ Impact on organisation
  - ○ Impact on treatment

4. Inter-agency working

Aim: To explore the level, nature and effectiveness of inter-agency working around treatment.

Ask participant to describe the nature of inter-agency working (and their view of how it should work). Examples of other agencies may be other treatment programmes or the Police/Prison/Probation Services. It may be helpful for the respondent to think of a fictitious/or anonymous factual treatment case and describe the interrelationships between agencies. In the course of the description, probe:

- The extent and range of relationships between the treatment centre and different agencies (specifically probe for residential treatment provision in the DAT). For each agency relationship, describe:
  - ○ The purpose of the relationship
  - ○ Frequency of contact within treatment
  - ○ How the relationship is conducted (face-to face, telephone-conference, email)
  - ○ How it relates to outcome
  - ○ Perceived effectiveness of relationship
- Process for developing and maintaining effective inter-agency working
  - ○ Formal policy
  - ○ Nature and extent of monitoring
  - ○ Barriers/ facilitators to effective working
- Perceived impact of inter-agency working
  - ○ Impact on colleagues
  - ○ Impact on clients
  - ○ Overall impact on outcome
- Nature of client follow-up/aftercare post-treatment
  - ○ Formal policy
  - ○ Responsibility (treatment centre or inter-agency partners)
  - ○ Monitoring
  - ○ Impact on outcome

5. Referral process

Aim: To examine the process (organisational), dynamics (organisational and interpersonal) and effectiveness of referrals into treatment and to other agencies.

Ask participant to describe the referral process, examining the formal and informal routes to treatment. In the course of this, probe:

- Formal policy
  - ○ Within programme
- Referral routes and sources into treatment programme
  - ○ Who makes referrals
  - ○ Primary and secondary routes
  - ○ Voluntary vs. criminal-justice referrals
  - ○ Type of CJS referrals
  - ○ Who does comprehensive assessment
  - ○ Who is care coordinator
- Timing
  - ○ Adequacy of timing/deadline from referrer
- Decision making
  - ○ Process for allocating treatment places
  - ○ Who are the key players
  - ○ Availability of key information (care plans, comp. assessments)
  - ○ Service user involvement
- Adequacy of process
  - ○ Suitability of client referred
  - ○ Level of formal/informal monitoring
- Onward referral routes (and sources from treatment)
  - ○ Who makes referrals
  - ○ What kinds of services
  - ○ Availability (waiting-list issues)
  - ○ Use of residential rehabilitation

6. Treatment process

Aim: To encourage a detailed description of the treatment process. Each treatment 'component/ module' should be fully explored.

Before exploring individual treatment components, begin with short discussion of underlying assumptions, primarily regarding:

- Definition of treatment

Ask participant to describe the treatment process from start to finish, component by component. For each component, probe:

- The aim of the intervention
- Length of the intervention
- How are clients engaged (both at the start and throughout the treatment episode)
- Techniques/methods involved
  - Psychological intervention (group vs. individual)
  - Medical intervention
  - Information giving
- Staff delivering the component
  - Qualified/unqualified staff required
  - Single vs. multiple staff delivery
  - Division of roles within the component
- How is this component nested/inter-related to other components
  - Timing
  - Care planning
  - Inter-locking aims
- Staff continuity throughout the different treatment components
- Relative contribution of each component to the overall treatment pathway/programme
- Drop-out rate
  - Factors affecting drop out
  - Impact of drop out
- How decide when treatment is complete

7. Barriers/ facilitators to successful treatment

Aim: To explore the individual (I), structural (S) and procedural (P) barriers and facilitators to success.

Conceptualising addiction

- Definition of 'addiction'
- Route causes/model of addiction

Conceptualising success

Ask the participant to explore:

- What constitutes a successful/unsuccessful outcome
- What are realistic/unrealistic treatment outcomes
  - Complete cessation of drug use
  - Management of addiction
  - Improved mental/physical health
  - Reduction in offending behaviour

- Reduction in risk behaviour (drug-related/sexual-related)
- Other markers

- What does the programme or intervention do well/ not so well
- What could be improved

Invite the participant to think of two case studies, one with a positive and one with a negative outcome (positive outcome case must have been in treatment for a significant amount of time). Describe the case studies separately, within each case study probe for:

Case Background (I)

- Age
- Gender
- Offence (if relevant)
- Previous treatment
- Type and extent of drug use

Referral Route (P)

- Impact of referral route
- Probe for comment if CJS referrals.
- Agency involved
- Suitability of treatment to individual case

Treatment (S)

- Attendance
- Engagement
- Group process (where applicable)

Outcome (P)

- Completed vs. non-completion (including those asked to leave the programme)
- How did individual respond to post-treatment provider report/summary
- Level of inter-agency through care/information sharing

Reflections

Reflecting on the two case studies examined, ask participant to explore:

- Would changes to any procedural or practice aspects impact outcome
  - Explore nature of proposed changes
  - Who should contribute to redesign

8. Perception of role

Aim: To examine personal perceptions of treatment, impacts of the work on providers, and closing thoughts.

- Decision to work in statutory/non-statutory agency
- Development and supervision
  - Need
  - Source
  - What received
  - Impact
- Impact of work
  - Self
  - Colleagues
  - Family
  - Friends
- What are the biggest challenges facing providers (probe for funding/targets/staff-client ratios)
  - Solutions to overcome
  - What can we learn from their experiences
- Personal motivators for working in drug treatment
  - Retaining factors
- What are the biggest rewards for providers of drug treatment services
- Any other closing comments

Treatment-seekers' topic guide

1. Introduction

Aim: To introduce the discussion and NatCen.

- Introduce self, NatCen
- Introduce research: see above
- Explain: confidentiality, tape recording (reconfirm consent when the tape recorder is running), length (about an hour and a half) and nature of discussion (specific topics to address, but conversational in style), reporting and data storage issues
- Any questions?

2. Present circumstances

Aim: To explore the participant's life and wider social network in recent months.

- Age
- Current housing
  - Where living

- How long lived there
- Live alone/with others
- Main daytime activity

Probe for length of time doing each activity mentioned.

- Full-time employment
- Part-time employment
- Further education/Govt. training scheme
- Unemployed
- Relationship status
- Wider family
  - Where living
  - Level of contact
- Friendships
  - Any/level of contact
  - How important
  - What activities with friends
- Finances
  - View of current financial status
  - Difficulties/debt
- Health
  - General perception
  - Any difficulties

Only probe if major illness is disclosed – if disclosure is made, use discretion regarding level of detail explored.

3. Drug use profile

Aim: To examine the type and level of drug use, participant attitudes and the social context of usage.

- Types of drugs ever used (for each type explore)
  - First use
  - What it is like to take drug
- What going on in life at time

Probe for general background information

- Amount and frequency since first use

Probe for use of drug in the last month.

- Environment in which drug use occurs
- Use alone or with others (who)
- Motivation for use (what do they get out of it)

Probe for peer or family influence.

- Sources of drugs

- Ever source for others
- Any dealing
- How pay for drugs
- How important is access to a supply of drugs
  - Compare to other essentials such as food, clothes, music etc.

Invite the participant to think about his or her own perception of their drug use

- What impact does drug use have on their life
  - How normal/problematic is their drug use
- Family/friends knowledge of/attitude to their drug use

Probe for whether family and friends also use.

4.   Overview of treatment career

Aim: To examine the previous treatment experiences of that participant.

Invite the participant to think about their previous treatment career, from the first ever episode up to the last or current treatment encounter.

Where there are more than two episodes, address issues thematically asking for examples from each episode. Where there are two or fewer episodes, for each encounter (except the current or most recent), probe for:

- Name of intervention
- When occurred
- Referral route
  - Why/who referred
  - How was programme chosen above others
  - Attitude towards referral (perceived choice)
- Intervention type
  - Length of intervention
  - Single vs. multiple modules
  - Perception of staff
  - Environment delivered
  - Attendance

If poor attendance disclosed, probe for reasons.

- Completed whole intervention
- Level of after-care
- General impression of intervention
- Personal outcome
  - Long-term change/short-term change/no change

- Management/stabilised use
- Other outcomes (criminal issues etc.)

5.   Current treatment

Aim: To explore the participant's pathway into their current treatment episode; to provide some context to outcome by exploring feelings and beliefs before their most recent episode of treatment; to examine the participant's views of the different aspects of treatment, and the staff and peer dynamics, (comparing this to any previous treatment episodes).

Note: Invite participant to reflect on their pathway into their current/just completed treatment. Probe for:

Referral route

- When/why/by whom
- How was programme selected (how was treatment need developed)
- Information provided about intervention
- Opportunity for questions
- Attitude towards referral (perceived choice)
- Time between referral and commencing treatment (waiting list)

Pre-treatment attitudes

In the course of the discussion, probe for:

- Treatment expectations
  - What do/did you want to get from it
  - How important was/is treatment to you
- Motivation for commencing treatment
  - Health
  - Self-efficacy (self-esteem/self-management)
  - Family/friendships
  - Stop offending/remain out of custody
- Family's view of treatment
- Friends' view of treatment
- Where do you want to be in 12 months
  - Goals (i.e. abstinence etc.)

Current/most recent treatment experience

Ask the participant to talk about a typical treatment encounter they have recently/are currently receiving. [Where the experiences are made up of more than one encounter] what are the different components comprised of? For each component, probe for:

- Name of the component
- How long does this component last (number of sessions etc.)
- How does it work
- Who delivers it
  - Perception of staff delivering
- Environment delivered (individual vs. group)
- If group: Process/relationships with others
- Anticipated outcome
  - Cessation of use or other issues (improved self-efficacy etc.)
- How do the components discussed link/work together
  - Compare in terms of style
  - Effectiveness of links

Relationships with service providers (therapists/key workers)

- Views of service providers
  - Experiences (positive vs. negative)
  - Skill
  - Treatment process maintained
  - Supportive/safe environment (in/out of treatment session)
  - Compare/contrast with providers from previous treatment

Relationships with other clients

- Views of clients in their programme
  - Experiences (*positive vs. negative*)
  - Treatment reflecting client diversity
  - Perceived motivation of others
  - Supportive/safe environment (in/out of treatment session)
  - Compare/contrast with clients from previous treatment

Overall View

- Compare/contrast with any previous treatment episodes
  - Individual needs met

If still in treatment

- Whether they will complete

If completed treatment

- What kept you in treatment on this occasion

- Personal issues
- Peers/family
- Effective treatment delivery

If left treatment early

- Why left treatment early

6. Current/most recent treatment effectiveness

Aim: To map treatment effectiveness across two dimensions. Dimension 1: mapping treatment outcome (i.e. does treatment address user needs?). Dimension 2: what contributes to outcome (i.e. range of services; nature of referral route).

- How effective was treatment experience

Probe for positive and negative outcomes and how current treatment experience compares with the previous experience.

- Were the stated expectations met
- What changes as a result of treatment
- Aspects of life changed (what aspects are better/worse)
  - Personal emotional wellbeing (health)
  - Complete cessation of drug use
  - Management of addiction (for each drug)
  - Level/frequency
  - Improved mental/physical health
  - Reduction in offending behaviour
  - Reduction in risk behaviour (drug-related/sexual-related)
  - Housing stability
  - Friendships
  - Social life

What parts of their treatment experience contributed to the positive/negative changes described (*refer participant back to the different components described*)

- Were all (multiple) needs met in treatment
  - Homelessness
  - Mental health issues
  - Access to other services (training, education etc.)
  - Evidence of multi-agency working
  - Evidence of after-care

7.   Closing comments

- What can we learn from your treatment experiences
- What can you advise us to do differently
  ○ Suggested improvements
- Future plans for self

Appendix 3   Analysis

The data in this study were analysed with the aid of Framework (Ritchie *et al.*, 2003), a systematic approach to qualitative data management that was developed by NatCen and is now widely used in social policy research (Pope *et al.*, 2006). Framework involves a number of stages. First, the key topics and issues which emerge from the research objectives and the data are identified through familiarisation with the transcripts. The initial analytical framework is then drawn up and a series of thematic charts or matrices are set up, each relating to a different thematic issue. The columns in each matrix represent the key sub-themes or topics whilst the rows represent individual participants. Data from verbatim transcripts of each interview are summarised into the appropriate cell. In this way, the data are ordered in a systematic way that is grounded in participants' own accounts yet oriented to the research objectives.

This approach was supported by a bespoke software package, also developed by NatCen. The software enabled a flexible approach to the creation of the matrices, allowing new columns or 'themes' to be added during the process of data management. This software also enables the summarised data to be hyperlinked to the verbatim text in the transcript so that it is possible to move back and forth from the more abstracted summary to the original data at will, depending on the level of analysis and detail required. Finally, the cases and themes that were displayed could be chosen with complete flexibility, easily allowing cases to be ordered, compared and contrasted. The Framework approach and the Framework software meant that each part of every transcript that was relevant to a particular theme was noted, ordered and was almost instantly accessible.

The final stage of analysis involved working through the charted data in detail, drawing out the range of experiences and views, identifying similarities and differences, developing and testing hypotheses, and interrogating the data to seek to explain emergent patterns and findings. In drawing the material together, the aim was to display and explain differences and similarities in the perceptions of the different service providers and service users, using each data set to enhance our understanding of the others and to derive a deeper level of understanding of how the system worked and its impact. The themes used to manage the data for both service provides and treatment seekers are set out below.

Framework for service providers

- **Background and context** – covering aspects of the job role and drug context in the local area.

- **Organisation** – including its structure, ethos and approach to treatment.

- **Inter-agency relationships** – care coordination and overall strategy in inter-agency working.

- **Assessment and treatment** – covering the assessment process; the broad demographic of clients presenting; and, an overview of the approach to treatment.

- **Interventions** – the range of interventions covered by the agency and the approach to aftercare.

- **Impact** – covering the known and perceived impact of treatment on clients with illustrative case study examples.

Framework for treatment seekers

- Background and context – including living arrangements, family situation, and previous contact with the CJS.

- Drug use profile – discussing the history of participants' involvement and use of drugs, including context in which they started using drugs and motivations for doing so.

- Treatment career – covering respondents' views and experiences of past treatment experiences.

- Current treatment – covering the overall experience of the treatment process including pathways into the current or most recent episode of treatment and the

elements of treatment covered during the treatment period e.g. group therapies, counselling and aftercare.

- Impact – including all aspects of treatment, facilitators and barriers to success of treatment, and unmet needs.

- Recommendations for treatment services

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