Sick, deviant or something else entirely? The implications of a label on drug treatment progression, recovery and service delivery

A thesis submitted to the University of Manchester for the degree of Doctor of Philosophy
in the Faculty of Humanities

2013

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Word count: 79492
ABSTRACT OF THESIS submitted by Samantha Kerry Weston for the Degree of Doctor of Philosophy and entitled:

‘Sick, deviant or something else entirely? The implications of a label on drug treatment progression, recovery and service delivery’

Month and Year of submission       July 2012

Abstract

In an effort to shift away from the narrow medical model of drug treatment the Advisory Council on the Misuse of Drugs (ACMD), in 1982, introduced the idea of the ‘problem drug user’ (PDU) and recommended a multi-disciplinary approach in order to meet the increasingly evident multiple and complex problems presented by dependent drug users. However, despite the development of a series of drug strategies (HM Government, 1995; 1998; 2002; 2008; 2010) and vast increases in funding, dependent drug users are still struggling to receive the services they require to address their diverse problems (Neale, 2008; Buchanan, 2010). Through an analysis of in-depth interviews with dependent drug users and their keyworkers this thesis seeks to explain these deficiencies.

The author argues that the broad umbrella of drug policy that has adopted a framework of risk-based strategies to regulate and control drugs and drug users has focused on the social and economic costs associated with problem drug use, particularly in relation to the belief that much acquisitive crime is drug-related. Hence, the focus has not been on the problems that drug users have but on the problems they cause. The medical model that has dominated the treatment of addiction has been reinforced, therefore, not only because ‘drug addiction’ has been described as a chronic and relapsing condition (NTA, 2002), but also because of the wider social control objectives (crime reduction, in particular) that this approach delivers (Lind et al., 2005; Gossop, 2005; Millar et al., 2008). The author examines the implications of these drug policy directions on the treatment journeys of dependent drug users. Firstly, the author demonstrates how the confluence of the health and crime reduction agendas has led to the paradoxical perception of drug users as being ‘sick-but-deviant’ that has served to exacerbate their stigmatised identities. Secondly, the author suggests that the closer alignment between the drug treatment workforce and the criminal justice system has led to the isolation of drug treatment from wider health and social care services. Together, these two consequences of drug policies have created further barriers to service access and successful recovery, thereby providing an explanation for the unmet need of dependent drug users attending treatment services.
**Declaration**

No portion of the work referred to in the thesis has been submitted in support of an application for another degree of qualification of this or any other university of other institute of learning.

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Dedication

To my family and in memory of my nana, Peggy, and my grandad, Samuel Bloor, who always knew I had this in me

Acknowledgements

I would like to take this opportunity to express my gratitude to all those people who have given me their invaluable help and support in the course of the production of this doctoral thesis.

First among these are Judith Aldridge, Mike Donmall and Toby Seddon who have inspired and encouraged me and who have been endlessly patient in their roles as supervisors. Invaluable support came also from staff, students and friends at the School of Law, and National Drug Evidence Centre, University of Manchester, particularly Tim Millar, Andy Jones and Julie Chadwick.

I also wish to extend my appreciation to the service users, drug workers and other professionals within the North West who gave up their valuable time to talk to me. Special thanks must go to those who facilitated my numerous visits to Drug Action Teams and drug treatment services, permitting me access to a wealth of information.

I have more recently benefited from the support and encouragement extended to me by my colleagues at the School of Sociology and Criminology, University of Keele, who have given me a reason to get this thesis completed.

I must also thank my friend, Hillary Jones. Without her support and encouragement I would never have embarked upon this journey, much less finished it.

My love and gratitude must also go to my partner, Tony, my children, Eden and Oscar, my parents and extended family, who have been endlessly supportive, never doubted me and always believed that I could succeed. Thank you.
List of Abbreviations

ACMD – Advisory Council on the Misuse of Drugs
BMJ - British Medical Journal
CARATS - Counselling, Assessment, Referral, Advice and Throughcare Service
CDT – Community Drug Team
CFI – Central Funding Initiative
DAT – Drug Action Team
DDU – Drug Dependency Unit
DIP – Drug Interventions Programme
DMD – Drug Misuse Database
DRR – Drug Rehabilitation Requirement
DTORS - Drug Treatment Outcomes Research Study
DTTO – Drug Treatment and Testing Order
NTA – National Treatment Agency for Substance Misuse
NTORS – National Treatment Outcomes Research Study
PDU – Problem Drug User
RoB – Restriction on Bail
WHO – World Health Organisation
Part I
Chapter 1: Introduction

1.1. Origins of the Thesis

The emergence of ‘risk’ as the dominant framework to be applied across a whole range of areas has been identified as a significant part of late modernity (Beck, 1986; Giddens, 1990; 1991). According to Garland (2004:171) late modernity has generated ‘new risks, insecurities and opportunities’ that have created new policy predicaments and have resulted in new policy responses. Identified as a ‘risk’, illicit drug use and drug users have become the subject of a proliferation of government-led drug strategies and interventions which aim to reduce so-called drug-driven offending. This direction has resulted in some quite dramatic changes in British drug policy, as Seddon, Ralphs, and Williams (2008: 818) acknowledge:

‘It is sometimes difficult to convey fully to those outside the field the enormity of the transformation that appears to have taken place in British drug policy in recent times’.

This statement is no doubt true and the article from which it was drawn puts forward an explanation for the transformation suggesting that ‘British drug policy… appears as one instance of the wider rise of risk-based forms and practices of government in late modernity’ (2008: 825). However, the literature appears to have paid little attention to the practical implementation and operation of current drug policies, particularly with regards to the treatment journeys of dependent drug users and ultimately their chances of recovery. This thesis attempts to address this deficit. Not only does it investigate the treatment journeys of dependent drug users, but does so by situating these journeys within the framework and direction of current drug policies. It identifies and explains some of the key issues or factors that may determine access to drug treatment, other healthcare and social services necessary to meet the multiple and complex problems presented by dependent drug users. This approach will allow for the development of appropriate recommendations that may improve the treatment journeys of dependent drug users and help them to address the
multiple and complex problems with which they often present. It is in relation to this final point that I wish to elaborate on here.

Consistent in the literature is the belief that dependent drug users often have at least one other significant issue or problem such as mental and physical health problems, inadequate housing, skill deficits, unemployment, inadequate or anti-social support networks, financial issues (Drake and Wallach, 1989; Johnson, 2000; Frederick, et al. 2003; Neale, 2001; 2008), and that these factors may propel individuals into criminal behaviour as a survival strategy in the community (Hartwell, 2004). The multiple and complex problems presented by drug users have been recognised by policy-makers and advisors who have consistently recommended public sector agencies collaborate in order to address such needs. This recognition has come alongside strong political support for the reduction of drug misuse resulting in the development of a series of drug strategies (HM Government, 1995; 1998; 2002; 2008; 2010) and vast increases in funding.

In spite of these developments it appears that dependent drug users are still struggling to receive the services they require (Neale, 2008; Buchanan, 2010). Drawing on data collected from focus groups Revolving Doors (2010:4) argue that “drug workers only assess and address drug needs, in particular methadone provision, without taking in to consideration other support needs”, as one of their participants highlighted:

“If you say drugs and then depression, the first thing they deal with is your drugs and that’s that. But there’s a list of things you need dealt with.”

This thesis aims, therefore, to provide an explanation for what seems to be the continued neglect of the various treatment needs presented by dependent drug users and, to reiterate the point made above, to offer some recommendations for drug policy makers and commissioners.

Before introducing the content of this thesis it is necessary to provide more detail relating to the contextual basis for doing this research. To begin with it is important to illustrate not only the extent of problem drug use in the UK but also the extent of the multiple and often complex problems presented by dependent drug users. These complexities raise questions about the adequacy of the terminology used to describe this group of individuals. Taking
into consideration the range of multiple problems presented by these people terms such as ‘drug dependent’ and ‘addict’, for example, appear insufficient. Also insufficient are the responses that have been made to address these various problems.

1.1.1. The multiple and complex problems of ‘problem drug users’

The latest official figures suggest that there are an estimated 321,229 problem drug users (PDUs) in England, corresponding to 9.41 per thousand of the population between the ages of 15 and 64 (Hay, Ganon, Casey, and Millar, 2010). PDUs are defined for the purposes of such estimates as users of heroin and/or crack cocaine (Hay et al., 2010:2). There are other definitions but ‘in essence the group typically consists of heroin and crack users who are involved in drug dealing and acquisitive crime and suffer from drug-related health and other difficulties’ (Spencer, et al. 2008:7).

Clearly, not all problem drug users attend treatment. According to the National Drug Treatment Monitoring System (NDTMS) 204,473 people aged 18 and over were in contact with structured treatment during 2010/11 (Roxburgh, Donmall, Wright and Jones, 2011). Eighty one per cent of these were opiate users accounting for 52% of the estimated population of problem drug users. Given that there are over 150,000 users of heroin in the UK and given its association with more harm than any other drug (Reuter and Stevens, 2007) it is perhaps of no surprise that it has been the focus of British policy concerns since the mid-1960s.

Most problem drug users have at least one other significant issue or problem, such as inadequate housing, skill deficits, unemployment, mental health and offending problems. Using recent research and monitoring figures the sections that follow illustrate the extent of the multiple and often complex problems presented by this group of individuals.

1.1.1.1. Housing

There is no single, substantive, national data set that identifies co-existing drug use and housing need. The most extensive source relating to drug users is the NDTMS, which in 2011 reported that 24% of drug users presenting to treatment had a housing problem
Other studies, however, have found that up to 40% of dependent drug users presenting to services are living in unstable accommodation (Jones, et al 2007; Gossop, et al 2003). Similarly, Kemp et al (2006) found that over a third of drug users entering treatment in Scotland were homeless at some point during the study. Applying these figures to the most recent drug treatment population figures, of the 204,473 people in contact with drug treatment for the year 2010/2011 (Roxburgh, Donmall, Wright and Jones, 2011), from approximately 49,074 (24%) to 81,789 (40%) have a housing need.

Importantly, it has been suggested that accommodation status is likely to determine the success of drug treatment. Evidence suggests that those leaving drug treatment without their housing needs being addressed are more likely to relapse (Phinney et al., 2007). The majority of rough sleepers, for example, use illicit substances. Randall and Brown (2002) reported drug use by 50-80% of rough sleepers in some areas. Furthermore, a Crisis Report on homeless substance users in London found that 83% of the sample had used a drug – excluding alcohol – in the last month, and almost half of these had injected. The report further stated: ‘Drug use may well be a trigger for homelessness then, but homelessness is clearly a stronger trigger for drug use’ (Fountain and Howes, 2002).

The relationship between illicit drug use and homelessness is complex and mutually reinforcing; homelessness leads to an increased risk of drug use, and drug use leads to an increased risk of becoming homeless. Drug use often disrupts relationships with family and friends and often cause people to lose their jobs. For people who are already struggling to pay their bills, the onset or exacerbation of addiction may cause them to lose their housing. According to Didenko and Pankratz (2007), two-thirds of homeless people report that drugs and/or alcohol were a major reason for them becoming homeless. In many situations, however, illicit drug use is a result of homelessness rather than a cause. People who are homeless often turn to drugs and alcohol to cope with their situations. In other words, they use illicit drugs in an attempt to attain temporary relief from their problems.

Therefore, having a secure place to live is an important factor in the rehabilitation of dependent drug users. This point was recognised by the Office of the Deputy Prime
Minister (2005) who suggested that ‘appropriate and sustainable housing is a foundation for successful rehabilitation of drug users…and is crucial in sustaining employment and drug treatment’ (Office of the Deputy Prime Minister, 2005:2). This thesis examines the importance associated with having a secure place to live according to dependent drug users and analyses the extent to which it does or does not determine the direction of their treatment journey.

1.1.1.2. Education and employment

Many of those presenting to drug treatment have poor educational attainment levels and are unemployed. The Drug Treatment Outcomes Research Study (DTORS) (Jones, et al., 2007) showed that 38% of drug users presenting to treatment services had left school before the age of 16, with a further 49% having left full-time education at age 16 or 17. Only one in ten (9%) of treatment seekers were in employment, one per cent were in training and one per cent in education. The majority of those presenting to treatment were not in work, whether unemployed and looking for work (28%), unable to work due to long-term sickness or disability (25%), or unemployed but not looking for work (24%) (Jones, et al, 2007). Applying these figures to the most recent drug treatment population figures, of the 204,473 people in contact with drug treatment for the year 2010/2011 (Roxburgh, Donmall, Wright and Jones, 2011), only 18,403 are likely to be in employment.

Many commentators have suggested a clear relationship between the use of ‘hard’ drugs, such as opiates or crack cocaine, and unemployment (Peck and Plant, 1986; MacDonald and Pudney, 2000; 2001; South, et al. 2001). Problems often experienced by dependent drug users such as, poor educational attainment, mental and physical health issues, offending, financial problems, and stigma may act as barriers to finding and maintaining employment (Sutton, et al. 2004; Spencer, et al., 2008). Research has suggested that it is important, therefore, to address these entrenched problems before it will be possible to tackle employability (Richards and Morrison, 2001). As some researchers have argued, ‘employment is unlikely to be a priority for dependent drug users until they feel physically and mentally well, until they have a secure home to return to at the end of the day, and until their daily routines are not constantly interrupted by the urgency of taking more drugs’ (Kemp and Neale, 2005:41). This thesis, therefore, considers the extent to which
employment is a priority for dependent drug users and the factors which, in their opinion, impact upon finding and maintaining employment.

1.1.1.3. Mental health
Given the evidence for their multiple interacting and mutually reinforcing problems and needs it is not surprising that many illicit drugs users also experience mental health problems.

The existence of co-occurring drug use and mental health problems among those presenting to drug treatment and mental health services has been the subject of increasing research and concern, mainly in the US and more recently in the UK. The co-morbidity of mental health and drug misuse related needs has been associated with poor treatment compliance (Pristach and Smith, 1990), and increased risk of offending (Hartwell, 2004; Johnson, 2000). However, despite increasing recognition of the need to develop interventions that respond to co-occurring drug use and mental health problems, there is only limited evidence to inform this (Weaver et al., 1999; Schulte and Holland, 2008).

The substantial variation in the prevalence of co-occurring drug use and mental health has made the comparison of studies and the collation of an evidence base inherently difficult (Wittchen, 1996). For example, depending on methodological factors such as design, sampling, and diagnoses, prevalence studies have reported co-morbidity rates of drug use and mental health varying from as low as 5% in the UK for current rates of prevalence (Condren, O'Connor, and Browne, 2001; Duke et al., 2001) to as high as 47% in the US for lifetime rates of prevalence (Reiger et al., 1990). Furthermore, many of the studies examining the prevalence of co-morbidity have usually focused on the extent of drug misuse among individuals with mental health problems (Drake and Wallach, 1989; Menezes et al., 1996; Wright, 2000; Kamali et al., 2000; Graham et al., 2001; Condren, O'Connor, and Browne, 2001; Duke et al., 2001; Weaver et al., 2003; Cantwell, 2003; Frisher et al., 2004). Few, however, have focused on the converse: the extent of mental health problems amongst individuals treated for their drug misuse, and studies that have taken this approach have produced astonishing results.
Weaver et al. (2003) reported a massive 75% of drug service clients as rating positive for at least one psychiatric disorder. A psychotic disorder was present in 17 patients (8%), personality disorder in 80 (37%), severe depression in 58 (27%), and severe anxiety in 41 (19%) indicating the need for cross-service or integration of care between mental health and substance misuse teams. Similarly, Sacks and Ries (2005, cited by Flynn and Brown, 2008), reported that 50% to 70% of clients attending drug misuse treatment showed lifetime histories of mental health problems, and Watkins et al. (2004) screened admissions to three outpatient substance misuse treatment services and found that approximately 50% had co-occurring mental health disorders. The Department of Health has estimated that approximately 30% of clients presenting to substance misuse services could be identified as having co-existing drug misuse and mental health needs (Department of Health, 1998). This estimation is supported by findings from DTORS, which found that 23% of treatment seekers reported that they had been previously diagnosed with a mental health condition, 37% had been referred to a psychiatrist, psychologist or other mental health worker at some point, and 28% had received psychiatric treatment in the past, with 11% of all treatment seekers doing so within the last three months (Jones et al., 2007). Applying these figures to the most recent drug treatment population figures, of the 204,473 people in contact with drug treatment for the year 2010/2011 (Roxburgh, Donmall, Wright and Jones, 2011), from approximately 61,342 (30%) to 153,355 (75%) could also be suffering from a mental health problem.

The treatment of drug-users with co-occurring drug use and mental health problems is a major challenge to substance misuse and mental health services (Clark, Ricketts, and Mchugo, 1999). Treatment providers generally agree that clients presenting with both drug use and mental health problems are more difficult to treat (Leshner, 1997; Sheehan, 1993), their treatment outcomes are generally poorer than those with single needs (McLellan et al., 1986), and they are less likely to complete a course of treatment for their drug misuse (Broome, Flynn, and Simpson, 1999). This thesis considers the extent to which the non-treatment of mental health problems determines the progression of the treatment journeys of dependent drug users and ultimately their recovery.
1.1.1.4. **Offending**

The concern with offending among the illicit drug using population has driven much of the drug policy implemented in the last 20 years. The high levels of crime committed by drug users (Inciardi, 1979; Dobson and Ward, 1984; Parker and Newcombe, 1987; Jarvis and Parker, 1989; Edmunds et al., 1999; Bennett, 1998; Gossop et al., 2000; Bennett et al., 2001; Best et al., 2001; Bennett et al. 2008) and the elevated level of criminal behaviour during periods of addiction (McGothlin et al., 1978; Ball et al., 1983; Nurco et al., 1985; Nurco, 1987; Nurco et al., 1989) indicate that the two behaviours often co-occur. Moreover, the National Treatment Outcomes Study (NTORS) found that over half of the people interviewed had committed a crime in the 3 months prior to entering treatment (Gossop, Marsden, and Stewart, 1998). Similarly DTORS demonstrated that 39% of treatment seekers had committed a crime in the last 4 weeks (Jones, et al., 2007). Applying these figures to the most recent drug treatment population figures, of the 204,473 people in treatment for the year 2010/2011 (Roxburgh, Donmall, Wright and Jones, 2011), over 100,000 people may have committed a crime in the 3 months prior to entering treatment and as many as 79,745 may have done so in the 4 weeks before presenting to treatment.

This research, however, does not support a causal link. In fact, the drug-crime link has been the subject of much debate. Drawing on previous research Seddon (2010a:149) identifies three basic hypotheses:

1. *Drugs cause crime.* Dependent heroin and crack users, with little or no legitimate income, are driven to commit property crime to generate money to buy drugs – ‘stealing to fund their habit’. This is sometimes called the ‘economic necessity’ model.

2. *Crime leads to drug use.* Drugs like heroin and crack are commodities that circulate in local criminal economies. Their consumption is part of leisure funded by success in crime.

3. *Drugs and crime are both linked to common factors/processes.* Heroin and crack use and involvement in property crime are not directly related but rather connected to common causal factors. A variety of common causes have been suggested from low self-control to poverty.

While all three hypotheses potentially support the link between drugs and crime the debate is still no further forward in demonstrating whether drug use causes crime or vice versa.
Nevertheless, drug policy has continued to focus resources on ‘problem’ drug users who are assumed to be involved in acquisitive offending in order to ‘feed their habit’ with the aim to reduce their drug-driven offending. One of the aims of this thesis, therefore, is to use this framework of drug policy to explain the treatment journeys of dependent drug users and the provision of treatment.

1.1.2. A problem with terminology?
Drawing on the literature that has been produced from both research and monitoring this thesis has so far emphasised the multiple and complex problems often presented by dependent drug users. This group of individuals, however, are often labelled according to their status as drug users. Terms such as drug dependent, addict, and ‘problematic drug user (PDU)’ are used, often interchangeably, to describe them.

The terminology used also differs according to the severity of mental health problems experienced among dependent drug users. For those who have a severe mental disorder, such as schizophrenia, terms such as comorbidity and dual diagnosis are used, suggesting the presence of two clearly identifiable and distinct disorders. However, for those with non-severe mental health problems, such as mood disorders including depression and anxiety, the terminology used reverts to drug dependent, addict or ‘PDU’. These terms do not sufficiently indicate the range of problems encountered by these individuals. Nor do they imply that the problems experienced are often multiple and inter-connected. Because their drug use runs parallel to their mental health problems and the range of psycho-social problems relating to offending behaviour, housing, skill deficits, employment, inadequate or anti-social support networks, and financial needs, it is difficult to determine whether one has caused the other, or alternatively whether they exist in absence of each other. One of the aims of this thesis, therefore, is to consider the impact of the terminology used to describe dependent drug users and to consider how this may affect their journey through treatment.
1.1.3. A problem with policy and strategic responses?

Despite the problems with terminology there has been some effort to address the multiple and complex problems presented by dependent drug users. Policy makers and advisors have consistently recommended the use of multi-agency working, particularly in respect of the ‘continuing and recurring crisis within the system of crime control and prevention’ (Crawford, 1994:497). Multi-agency working has, in fact, become a key feature of social policy (Heenan and Birrell, 2006), but ‘nowhere is it more apparent than in the treatment of drug misuse (Heath, 2010:185).

In 1982 the ACMD recognised the multiple problems presented by dependent drug users and introduced the idea of the problem drug taker in an effort to shift the attention away from the narrow medical model of treatment towards a multi-disciplinary approach:

The individuals with whom the treatment/rehabilitation system is concerned may have various problems arising from the misuse of drugs or from drug dependency or both. These are not solely physical or psychological problems, but also social and environmental problems, being concurrently psychologically dependent on some drugs and physiologically dependent on others, and at the same time having financial or legal problems or difficulties over housing. The response to the needs of drug misuse therefore requires a fully-multidisciplinary approach.

This approach should be problem oriented rather than specifically client or substance labelled. It would be similar to that in the field of alcohol where the term problem drinker has been defined by the Advisory Committee on Alcoholism. Thus, a problem drug taker would be any person who experienced social, psychological, physical or legal problems related to intoxication and/or regular excessive consumption and/or dependence as a consequence of his own use of drugs or other chemical substances (ACMD, 1982:34).

In 1993, the Department of Health and Home Office (Drake and Wallach 1989; Reed Report 1993) recognised the complexity of the problems faced by dependent drug users presenting to treatment agencies and highlighted the need for more effective joint working practices and liaison. Tackling Drugs Together (HM Government, 1995) reinforced the multi-agency approach to local drug strategy and commissioning through the creation of Drug Action Teams (DATs), comprising representatives from statutory agencies such as health, probation, police and local authorities. Similarly, The Task Force Review (1996) recommended that extensive liaison between mental health, drug services and the criminal
justice system needed to be established, and referral mechanisms be put in place to facilitate specialist psychiatric care for drug-users with mental health problems, and conversely, specialist drug care for mentally ill persons. Regardless of the approach, however, the guiding principle was to match the needs of the patient to the clinical team and its competencies, minimise multiple referrals and movements within multiple teams, and prevent exclusion from services (Raistrick, et al, 2006).

Since these recommendations have been made, integration of service provision, including multi-agency working has become a key policy issue. Several attempts over the last decade, including the implementation of numerous drug strategies (1995; 1998; 2002; 2008; 2010), *Models of Care for treatment of adult drug misusers: Update 2006* (National Treatment Agency 2006); *Drug Misuse and Dependence, and the UK guidelines on clinical management* (Department of Health (England) and devolved administrations, 2007), have been made which identify the importance of multi-agency working and service integration.

*The National Drug Strategy* (HM Government, 1998) stated that ‘because of the complexity of the problems, partnership really is essential at every level’. The emphasis on partnerships was furthered by the government instructing DATs to amalgamate and pool resources with their Crime and Disorder Partnerships to ‘provide the right framework to enable the more effective delivery of the crime reduction and drugs agendas’ (Home Office, 2003:1).

In 2002 Models of Care was implemented with the aim to guide the integration of care pathways for those treated for their substance misuse. The intention of these care pathways was to focus the multidisciplinary team who administer drug treatment on shared outcomes. A subsidiary of Models of Care is the Drug Intervention Programme, designed to refer drug misusing offenders from the Criminal Justice System into substance misuse treatment. It had long been recognised by key stakeholders (i.e. police, probation, courts, DATs, substance misuse teams, and Community Mental Health Teams) that from an individual’s initial contact with law enforcement, to sentencing, to prison or community and re-entry, there are numerous opportunities for such stakeholders to focus their efforts to improve the response to people with drug misuse problems. These opportunities identify the specificity of drug misuse problems amongst individuals and encourage key stakeholders to react in a
way that recognises individual needs by enabling access to effective treatment and services. The ultimate aim was to maintain the individual on a path toward recovery, and also promote public safety by getting people “out of crime and into treatment” (Home Office 2004:29).

Despite the consistency of these recommendations evidence suggests that the system is still failing to make adequate provision, particularly for those presenting with non-severe mental health problems. For example, in an analysis of data drawn from a sample of clients in three outpatient substance misuse programmes, it was found that half of those evidencing mental disorder never received treatment for it (Watkins et al., 2004).

A number of authors have suggested that the failure to make adequate provision results from the problems associated with multi-agency working. One of the major concerns relates to the ability and willingness of substance misuse and mental health services to treat clients with co-occurring mental disorder and drug dependency, a concern which is prominent in both the US and UK (Baldacchino, 2007). In the US, the mental health system is viewed as treating clients “with severe and chronic mental illnesses” but is not seen as “equipped to address the treatment of concurrent substance abuse disorders” (US Department of Health and Human Services, 2002:v, cited by Flynn and Brown, 2008). Conversely, “the substance abuse treatment system addresses all types of substance abuse disorders at all levels of severity; when necessary, many providers in this system are able to respond to mild to moderate forms of mood, anxiety, and personality disorders” (US Department of Health and Human Services, 2002:v, cited by Flynn and Brown, 2008). Consistent with the latter observation, clients with non-severe mental illness are more common in substance misuse services compared with the number of clients with severe mental illness (McGovern et al., 2006).

Reasons suggested for the somewhat fractured and limited implementation of multi-agency working have related to the wide range of systems, institutions and agencies involved, that often have very different goals, values, responsibilities, organisational structures, and resources. Weaver, et al (1999:137), for example, commented that ‘the medical model of psychiatric services, with their recourse to legal compulsion to treat those incapable of making rational health choices, contrasts sharply with the psychosocial orientation of
substance misuse services’. These difficulties have been amplified through the increasing introduction, over the last decade, of criminal justice agencies and their punitive mandate into the drug treatment milieu (Matrix Heath Knowledge Group 2008; Heath, 2010). Thus, the common language required for successful multi-agency working between such agencies may not exist.

This situation presents difficulties for both service management and clients (Kavanagh et al. 2000). Individuals with multiple and co-existing problems who are being treated by one service may not meet the criteria for treatment priority within another service (for example, their mental disorder or their substance misuse may not be seen as sufficiently severe). As a result, individuals are missing out on treatment essential to meeting their needs (Mangrum, Spence, and Lopez 2006). The separation of services also makes it difficult for staff to gain sufficient support and there may even be disputes about which service has primary responsibility for treatment and follow-up.

There is an argument, therefore, for service integration (i.e. the joining up of health and social services to provide a more holistic, ‘one-stop shop’). This type of service has the potential to provide benefits for the client in a number of ways. People who receive integrated services avoid the difficulties associated with negotiating two treatment elements, such as having to manage appointments across more than one system, and the possibility of receiving conflicting messages from various service providers (Becker 1963; Drake et al. 1998; Minkoff 1991). However, whether a model of integration can ever be achieved as a whole remains arguable.

For such a model to be effective some have suggested that there should be integration of the team, service components, treatment principles and philosophies (Edeh 2002), as it is these components that have been identified as being the barriers to achieving an integrated model. In a qualitative study examining the integration of community mental health teams with other health and social services, Rees et al (2004) found that the teams involved in the study identified many advantages of joint working, such as providing more benefit to the client by offering a single point of access to a ‘streamlined’ service. However, these views were not supported by a change in practice. Teams had not sufficiently implemented integration of care and this produced a number of barriers to joint working, such as, lack of
integration at higher organisational levels to support joint working and limited strategic input during the development phase of integrated working. Previous studies have also reported low compliance and barriers to implementation, including lack of training, clear implementation plan, ongoing support and feedback, and low morale (Jones 2000; Jones 2001).

Multi-agency working is, without doubt, difficult in any field (Carnwell and Buchanan, 2009) and a number of issues have been identified that may explain the existence of such difficulties within the context of drug dependence. The recommendations made to overcome such difficulties, such as those listed above, seem to have had very little impact, especially considering a point made by the 2010 UK drug strategy, *Reducing demand, restricting supply, building recovery: Supporting people to live a drug free life* (HM Government, 2010:5) which acknowledged the lack of an integrated approach to support people overcome their drug dependence: ‘although there has been some progress in tackling drug dependence, an integrated approach to support people to overcome their drug and alcohol dependence has not been the priority’.

This thesis must, therefore, surpass explanations already provided for the lack of multi-agency working within the field of drug dependence. In addition to identifying the various barriers to multi-agency working it must seek to explain why such barriers exist. This explanation will lead to recommendations that go beyond those that are often cited, such as increasing communication between services, and may help to sustain recovery and facilitate movement down one pathway over another.

### 1.2. Aims of the study

a) To provide an explanation for the treatment journeys of dependent drug users within the framework of current drug policies.
b) Identify and explain some of the issues which determine access to drug treatment, other healthcare and social services necessary to meet the multiple and complex problems presented by dependent drug users.

c) To develop recommendations for drug policy and treatment approaches that can sustain recovery from drug dependency.

1.3. The structure of the thesis

Fundamental to this thesis is the importance of drug policy in shaping the treatment journeys of dependent drug users. Chapter 2, therefore, examines and explains the process through which drug policy has been developed over the past 150 years. This chapter contends that while drug policy may have changed quite dramatically over the course of the previous 150 years these changes have occurred under a broad umbrella of policy that has adopted a framework of risk-based strategies to regulate and control drug use and the drug user; a framework which is used later in the thesis to explain the identity of the dependent drug user and the role of the drug treatment practitioner.

Alongside changing drug policy the perception of dependent drug users has also changed. Chapter 3, therefore, considers the implications of such a perception on the identity of the drug user, particularly the way in which they view themselves and are viewed by others. Drawing on two perspectives that have dominated the sociology of health and illness, the functionalist and interactionist approaches, this chapter reviews the theoretical and empirical literature on labelling and stigma, such as the work of Talcott Parsons, Howard Becker, and Erving Goffman, and considers the implications of these perspectives on the identity of the dependent drug user.

This chapter has demonstrated that multi-agency working has been the consistent solution offered to the multiple problems presented by dependent drug users. Such working practices, however, have yet to be effectively implemented, and where attempts have been made it has remained fractured and limited. In a review of the literature, therefore, Chapter
4 sets out to not only identify the barriers to multi-agency working, but by drawing on sociological theory attempts to explain why such barriers exist within the provision of drug treatment to begin with.

Chapter 5 describes the methodological approach taken to achieve the aims of the study. Information is provided about the data collection tools, the selection of the study sites and participants, how the data were analysed and importantly considers some of the ethical difficulties that were encountered in the research.

In an analysis of the data Chapter 6 examines the extent to which dependent drug users are stigmatised and how such stigmatisation affects their journey through treatment and access to services they might require. Moreover, through an application of Parsons’ (1951) sick role this chapter offers an explanation for the reinforcement and recreation of their stigmatised identity.

Drawing on the experiences of both service providers and dependent drug users, Chapter 7 demonstrates some of the difficulties that ensue when drug treatment practitioners attempt to work with other health and social care agencies. Furthermore, this chapter offers an explanation for such difficulties by considering the effects of the more recent use of the term ‘PDU’ on the role of the drug worker.

The final chapter presents the conclusion to the thesis. Firstly, it seeks to summarise the explanation provided in the thesis for the continued neglect of the various treatment needs presented by dependent drug users. Secondly, this chapter offers some recommendations for drug policy makers and commissioners.

The contents of this thesis are based on interviews with drug treatment service users, and their key workers. All of the service users interviewed were dependent opiate users and many were also users of crack cocaine. Therefore, throughout this thesis I will make reference to dependent drug users but what is meant by this term specifically is users of heroin and crack cocaine, thus for clarification purposes they are what some would regard as PDUs (Hay, et al. 2010; Spencer, et al. 2008). I have, however, chosen not to use this term for reasons that I hope will become apparent upon reading the thesis.
Moreover, the findings of this thesis help to explain why, and are therefore mainly relevant to, those dependent drug users who remain in maintenance and prescription treatment for many years, and are considered by many to be ‘stuck’ in treatment (Madden, et al., 2008). The findings might not be relevant to the wider population of drug users or those drug users in receipt of other types of drug treatment.
Chapter 2: From socially acceptable to problematic: The changing conception of drug use in the UK and related policy responses

"If men could learn from history, what lessons it might teach us! But passion and party blind our eyes, and the light which experience gives us is a lantern on the stern which shines only on the waves behind” [Samuel Taylor Coleridge, English poet and critic, 1772 -1834]

2.1 Introduction

A chapter about how perceptions of drug use has changed and how drug policy has responded to or perhaps informed such changes runs the risk of being interesting but lacking in explanation. In the absence of any close analysis it would appear that drug use and the responses to it over the past 150 years has changed so dramatically that a description of the past might appear to have little relevance. Characterised by its flexibility and its capacity to changing circumstances, however, drug use in the UK and the ‘British System’ of drug treatment has attracted much interest, amongst academics in particular (Berridge 1996a; Yates 2002; Duke 2006; Mold 2004; Seddon, Ralphs, and Williams 2008; Reuter and Stevens, 2008). The rationale for writing this chapter, therefore, is that an understanding of how drug policy has developed over time might provide some insights about how and why the current system of drug treatment operates as it does.

Alongside an examination of society’s changing conceptions of drug use, this chapter sets out to examine and explain how drug policy has responded to or perhaps informed such changes. It contends that while drug policy has changed quite dramatically at the micro level – for example, whether drug treatment should aim for abstinence or maintenance has been a lasting source of conflict – the rhetoric at a macro level has remained broadly the same. Since ideas about addiction emerged, and the introduction of legislation such as the 1868 Pharmacy Act, drugs have been subject to regulation and control. From the late
nineteenth century to the mid twentieth century, while drugs were affecting a relatively small and contained number of therapeutic ‘addicts’, drug policy developed at a relatively slow pace. Nevertheless, regulation and control remained at its heart, a programme which gained pace during the latter half of the twentieth century as drugs were affecting a growing proportion of individuals (Seddon, 2010) and as the emergence of ‘risk’ became the dominant framework within which such problems were understood and responded to (Beck, 1986; Giddens, 1990; 1991).

This chapter provides a chronological description of how society’s perception of drug use has changed and how, relatedly, drugs have become increasingly viewed as a source of ‘risk’ leading to expanding regulation and control. The chapter is split into two sections. The first section, section 2.2, focuses on the emergence of addiction as a disease, the implementation of the Pharmacy Act 1868 and Dangerous Drugs Act 1920, and the 1924 Rolleston report. It examines how regulation and control of drugs was a driving force behind much of the drug policy developed at this time, representing the beginnings of the ‘problematisation’ of drug use. The section that follows demonstrates how drugs became ‘problematised’, thus requiring further regulation and control. Section 2.3.1 demonstrates, through the emergence of the ‘PDU’ (although this was not the term used at the time) in the 1960s, how the problematisation of ‘drugs’ gained pace. Section 2.3.2 summarises evidence of the very substantial growth in heroin use that started to occur in Britain during the 1980s in a backdrop of deindustrialisation and increasing levels of unemployment. Section 2.3.3 describes how concerns about the spread of HIV amongst injecting drug users resulted in the re-emergence of a public health model, intended to engage a larger proportion of the drug misusing population in treatment, so as to reduce the risks and harms associated with their drug use and to protect the health of the wider community. Finally, section 2.3.4 draws on recent policy literature which emphasises the link between drugs and crime focusing attention on interventions that direct drug-misusing offenders out of crime and into treatment. Within each of these sections there will be an examination of how changes in drug policy agenda have fuelled debate among practitioners, policy makers and advisors; debates which remain prominent at the time of writing. Emphasis will also be placed on how the treatment of drug users has changed. What began as a system of private care administering detoxification or the prescription of heroin to an initially small number of
addicts eventually evolved, as the number of drug users increased and their needs changed, into a system requiring the involvement of a wide range of professionals from a variety of backgrounds, including but not exclusive to health; social care and criminal justice.

2.2. The emergence of addiction

Through the emergence of thinking around addiction as a disease and the introduction of the Pharmacy Act 1868 and the Dangerous Drugs Act 1920, the period described in this section signifies the first signs in the changing perception of drug use, from an activity which was regarded an unremarkable part of daily existence in nineteenth century Britain to one which necessitated regulation and control and the intervention of a medical practitioner.

2.2.1. Traditional views: The everyday use of drugs

Before medical theories of addiction and drug dependency began to emerge in the latter part of the nineteenth century drugs, opium in particular, were an unremarkable feature of daily existence in Britain. During the first part of the century, opium was the active ingredient in folk remedies made from seed capsules of the poppy, and a number of opium based medicines were available commercially to any retailer, including grocers, bakers, tailors, publicans and street vendors (Berridge, 1999a). In Britain, people could buy opium pills, powders and poultices, liniments, lozenges, syrups, suppositories and seed pods straight from the poppy stalk, and they were relatively inexpensive (Berridge, 1999a). Medicines containing opium were, in fact, a staple of British homes almost regardless of class. Such medicines were used to treat a long list of common afflictions including but not exclusive to bronchitis, cancer, cholera, diabetes, diarrhoea, depression, fatigue, gangrene, gout, menstrual symptoms, tetanus, tuberculosis and ulcers. In short, opium was as unexceptional in the early nineteenth century home as paracetamol in today’s.
Drugs, at this time, were not subject to criminal law controls and neither were they regarded as a particular problem (Seddon, 2010b:35). Although many of the symptoms we now associate with opiate addiction or dependence were evident in the nineteenth century, it is important to note that the terms such as ‘addiction’ and ‘drug dependence’ were not available and the social context in which they might have been observed was significantly different. While side effects such as tolerance (the necessity for greater dosages of the substance to produce the original effect) and withdrawal (the onset of pronounced and uncomfortable symptoms when doses of the substance are decreased) were common among users of opium in nineteenth century Britain they were much less remarked upon (Berridge, 1999a). Users of opium were likely to regard such symptoms as an illness for which opium was the appropriate remedy. Hence, opium use at this point was socially and morally acceptable. Heavy use of opium by the working class was largely ignored, and use by the rich ‘was not considered an exotic or secret vice, but the excess of normal indulgence, as drunkenness was’ (Hayter, 1968:34)

2.2.2 From ‘habits’ to ‘addiction’

It was only during the latter part of the mid nineteenth century that medical professionals began to formulate modern ideas about opiate use and addiction. While these ideas were already established for alcohol (Levine, 1978; Ferentzy, 2001), it was not until the rise of the hypodermic morphine injection that similar ideas were also being applied to opiate use (Albutt, 1870). Introduced into general usage by the early 1820s, morphine became more of a medical tool than a popular one as it was less familiar, less readily available and more expensive than unrefined opium. However, with the introduction of the hypodermic syringe, in the mid nineteenth century, morphine became even more effective and more restricted to professional medical practice. However, many practitioners were warning that ‘injections of morphia, though free from the ordinary evils of opium eating, might, nevertheless, create the same artificial want and gain credit for assuaging a restlessness and depression of which it was itself the cause’ (Albutt, 1870:329). Medical professionals began to define a new disease known primarily as ‘morphinism’: a set of symptoms associated with the prolonged hypodermic injection of morphine. Soon after, discussions of
mphinism became linked to debates about the treatment and legal control of alcoholism and alongside these emerged the new concept of ‘inebriety’.

Inebriety was defined as a disease of the nervous system, allied to insanity, characterised by an irresistible impulse to indulge in intoxicating liquors or other narcotics (Kerr, 1884, cited by Berridge, 1979). The disease took different forms according to the substance used - there was alcoholomania, opiomania, morphinomania and so on. The significant point about Kerr's work was that he united the disease of drug addiction with mental illness, hence allowing the disease of addiction to enter the domain of the psychiatrist. While relatively short lived, the concept of inebriety allowed for a ‘hybrid disease theory incorporating both medical and moral formulations’ (Berridge, 1979:77). In other words, addiction came to be viewed as both a medical condition and a moral failing:

‘Addiction was a disease and vice: it was moral bankruptcy, ‘disease of the will’, ‘a form of moral insanity’... This continuing moral component ensured a disease theory which was individually orientated, where the addict was responsible, through volition, for his own condition. Addiction was medicalised, but failure to achieve a cure was a failure of self-control, not medical science’ (Berridge, 1979:77, emphasis in original)

The ideas about drug use emerging in the latter part of the nineteenth century were reinforced by the impact of the Pharmacy Act 1868, which had limited the legal sale of opiates exclusively to licensed chemists, druggists, and pharmacists. According to some the Act represented ‘the first real attempt to introduce controls on the sales of substances like opium which up until then had in effect been treated scarcely any differently from any other commodity’ and ‘signals too the first establishment of what would later prove to be important ideas: that commodities of this kind pose potential ‘problems’ which may require governmental action; and that medical practitioners are appropriate people through which this action can be delivered’ (Seddon, 2010:33). It also represented one of the first signs of the development of links between medical surveillance and surveillance in other realms.
2.2.2. Prohibition

While the late nineteenth century marked the beginnings of the need or requirement to control drugs, drug prohibition in Britain really gained ground with the introduction of the Dangerous Drugs Act 1920, which prohibited the importation and exportation of certain dangerous drugs. Most notably, however, the 1920 Act made ‘drugs’ and the activities surrounding drug use a matter to be dealt with by the criminal justice system. Drug use remained a medical issue but, most importantly, had legal consequences.

Throughout the early to mid-twentieth century the health of addicts was provided for by the medical profession and the social problems that resulted from the use of drugs by the law-enforcement authorities (Berridge, 1999a). The 1924 Rolleston report accepted the disease model of addiction thus legitimating a medical response (Ministry of Health 1926). Addicts could be maintained indefinitely on their drug of addiction under the care of a General Practitioner. This was the ‘British System’ of the 1920s, its liberal approach being justified by the small, apparently socially conformist addict population who did not constitute a ‘problem’. At this point, medicine was responsible for the treatment of addiction that could result from drug-taking, and the penal system was responsible for dealing with the social consequences of the use of drugs, such as the connection to the criminal underworld, drug deals, petty theft, and prostitution. This was a ‘medico-legal alliance’ where the medical and social had distinct, but co-existing roles (Berridge, 1999a:278).

While the use of drugs did not represent much of a problem at this point the legislation introduced regulating and controlling the activities surrounding drug use signifies the beginnings of the ‘problematisation’ of drug use, a policy direction which gained pace in the latter half of the nineteenth and early twentieth centuries.

2.3. The ‘problematisation’ of drug use and the ‘need’ for regulation and control

Through the rise of concerns relating to public health and crime, drug use became quite firmly ‘problematised’ requiring not only the intervention of the medical practitioner but
also the intervention of other ‘social control’ agencies, of which the criminal justice system plays a prominent role. This transformation in the way in which drug users were viewed made way for the emergence and growth of the PDU.

2.3.1. The emergence of the ‘Problem Drug User’ (PDU) and the social control of addiction

The distinctions made between the roles of the medical and the social in the treatment of drug misuse became more blurred as the ‘social’ was more broadly defined and more closely linked to the ‘medical’ by the mid-twentieth century. Drug addiction represented not just a medical danger but also a social danger. As a result of contagious diseases such as tuberculosis doctors began to examine the relationships between people, and not just the environment, as a cause of disease (Armstrong 1983). This shift encouraged the extension of the medical ‘gaze’ from the individual to the whole community (Foucault 1973). The focus on the effects of drug misuse was thus no longer restricted to the individual but to society. The Interdepartmental Committee on Heroin Addiction (Ministry of Health 1965) drew on these developments when they defined addiction as a socially infectious disease. It is clear that through this description, the medical and social were brought even closer together, ‘if they were co-habiting partners before, they were most certainly married now’ (Mold 2004:502).

Defining addiction as a social disease allowed for the possibility of two different approaches: treatment of the sick individual, and control measures aimed at limiting the spread of disease within society. While the Brain Committee accepted that ‘the addict should be regarded as a sick person and treated as such’ (Ministry of Health, 1965:4) their proposals revealed concerns that ran beyond the treatment of the individual addict. As sociologists, Stimson and Oppenheimer (1982:54) argue ‘hitherto most discussions had focused on the medical treatment of addicted individuals. The new element introduced in the 1960s was the emphasis on the social control of addiction’. This change was attributed to the transformation in the population of addicts. Addicts were younger, working class, and had become addicted not as a consequence of medical treatment, but as a result of ‘recreational’ drug use. Heroin addiction had become a much greater social problem.
The Brain Committee (1965) recommended that both the treatment and control of drug addiction could only be managed by the introduction of specialised institutions – hospital based Drug Dependency Units (DDUs). Although both the health of the individual and the societal impacts of addiction were always a concern of drug policy, the DDUs represented a closer amalgamation of what had been characterised as ‘medical’ and ‘social’ responses. Initially operating as prescribing centres, it was believed that the ‘competitive’ prescribing by DDUs would undercut and curtail the development of a black market in drugs.

Achieving agreement on exactly what the DDUs should provide, however, was difficult. The Ministry of Health had little idea about how to implement a policy that would control the spread of addiction at the same time as providing treatment of individual addicts. It became apparent that the intention was for the clinics to have two roles – treatment of addicts who desired a cure (withdrawal, abstinence and rehabilitation) and the regular supply of heroin or other drugs to addicts who were not willing to accept treatment (maintenance) – the aim being to both control the spread of addiction in the wider population and treat the individual addict.

In consultation with a number of experts it was thought that the dual function to cure users of their addiction and to offer maintenance to those unwilling to accept treatment was somewhat contradictory. Although there were relatively few psychiatrists who had much experience of dealing with addiction in the mid-1960s, those who did could roughly be divided into two camps. Some specialists favoured a policy which would allow addicts who could not, or would not, give up heroin to be maintained on the drug (Beckett 1968), while others dismissed the prescription of heroin to addicts arguing instead for transferring them to the synthetic opiate substitute methadone and placing greater emphasis on ‘curing’ the individual addict rather than allowing them to remain hooked on drugs. (Bewley 1967). However, the Ministry of Health were unconvinced by this latter argument and decided that clinics would be permitted to prescribe heroin on a maintenance basis.

Upon the implementation of DDUs, unease about doctors having a specified role to play in ‘social control’ became more apparent. Doctors were unsure about the merits of the service they were to offer as ‘treatment’ and were reluctant to become involved in a project that was more concerned with the social control of addiction. For example, Beckett (1968:360)
argued that psychiatrists were ‘orientated medically, not sociologically, as in line with their training’. Doctors, he implied, were more interested in curing the addict than attempting to control the social problem of addiction.

By the 1970s many clinics began to introduce treatment policies that placed a greater emphasis on curing the addict of their addiction, rather than maintaining them on heroin for the benefit of society. Prescriptions for injectable heroin were gradually replaced with oral methadone as this was thought to be a more therapeutic approach (Stimson and Oppenheimer 1982). Furthermore, doctors began to push addicts into treatment programmes aimed at complete abstinence rather than indefinite maintenance. Elements of social control, however, were retained. Many clinics placed increasing constraints on patients’ behaviour, requiring them to pick up daily prescriptions or attend regular treatment sessions, if they did not want to be ‘punished’ by having their prescriptions reduced.

While the mid twentieth century saw the beginnings of some unease among medical professionals about their role in social control, the importance placed upon the regulation of drug use remained a primary concern for policy makers (Seddon, 2010). Previous legislation relating to the control and regulation of drugs was consolidated and extended by the Misuse of Drugs Act 1971, an Act which remains, at the time of writing, as the main piece of legislation covering the control of drugs and their categorisation. The Act created the offence ‘intent to supply’ and set harsher penalties for trafficking and supply, reinforcing the idea that drug use and the activities surrounding it should monitored and controlled. Furthermore, the Act quite firmly made drug use a matter to be dealt with by the criminal justice system.

2.3.2. Deindustrialisation, the rise of PDUs and the fall of DDUs

By the 1980s the UK was experiencing a process of deindustrialisation affecting labour-intensive industries as factories, shipyards, and mines closed down. Whole communities were destabilised by mass long-term unemployment. For the first time in the post war period, a generation of school leavers who would otherwise have secured employment in
apprenticeships, factories or semi-skilled positions found themselves unemployed. There was a growing realisation that some of these school leavers would never be able to find employment. This discarded generation was excluded socially and economically from the benefits widely available to those in work (Hutton, 1996; Buchanan, 2000) and it was in this environment that the youth of the 1980s turned to heroin in an attempt to block out the harsh social and economic realities of their lives (Buchanan and Wyke, 1987).

Refusing to acknowledge the structural causes of the 1980s drug problem, the UK Conservative Government adopted a high profile campaign, ‘Heroin Screws You Up’, portraying young heroin addicts as unkempt social outcasts who threatened the cohesion of local communities and placed lives at risk. Two groups emerged: one group, largely made up of unemployed working-class youth who lived on council estates, were seen as social deviants heavily involved in drugs and crime and causing havoc in communities; the other group, consisted of respectable youth who were at risk of being lured into drug addiction by evil drug pushers (Buchanan and Wyke, 1987).

Heroin addiction appeared to be a very different problem to the one encountered in previous decades. The first indication that the pattern of drug use was changing came in the form of an increase in numbers of notified addicts. The 3425 addicts notified in 1975 had risen to over 14,688 by 1985 (Hebblethwaite 1989). Despite better reporting of addiction, official figures were notoriously unreliable, so that the ‘real’ number of drug addicts could have been as much as five or even ten times greater than that reported (Spear, 1994).

Heroin addiction was not just increasing numerically; it also appeared to be spreading geographically. Heroin addiction was no longer confined to London. Manchester, Merseyside, and Glasgow were particularly affected, but heroin use was increasingly to be found in urban areas throughout the UK (Peutherer et al. 1985).

Much of the expanding heroin use was enabled by the expanding black market in illegally produced and distributed drugs. Heroin from Iran flooded the market and the amount of heroin seized by police and customs, likely to represent just a small fraction of the total smuggles into the UK, rose considerably (Pearson, 1987). At the same time, demand increased as DDUs cut down on the amount of heroin prescribed to addicts, replacing it
with methadone instead. Buying heroin on the black market was an attractive proposition for addicts who disliked methadone, as illicitly produced heroin at this time was both relatively pure and relatively inexpensive.

The influx of heroin from Iran, and later Afghanistan and Pakistan, had an important impact on the character of the British heroin problem. Heroin imported from these countries was particularly well suited to smoking rather than injecting (Griffiths, Gossop, and Strang 1994). Subsequently, there was an increase in smoking heroin in Britain during the 1980s. In 1979 most heroin users first took the drug intravenously but by the end of the 1980s the majority of new users began taking the drug by inhalation (Griffiths, Gossop, and Strang 1994). Furthermore, heroin users were not using only heroin, they were often taking a range of other drugs by a variety of routes. As the prescription of heroin to addicts became more controlled many users turned to other drugs. Street agencies and casualties were increasingly encountering so-called polydrug users who were not catered for by the DDUs. After some years of stability in terms of the drug problem, Britain was clearly in the throes of a ‘new drug problem’ (Stimson 1987) and responses to it were in turmoil. DDUs, which had formed the cornerstone of heroin addiction treatment policy since 1968, were increasingly unable or unwilling to respond to the needs of some patients. The ‘British system’ for drug treatment was failing, and the ‘clinic’ system which was the focal point of the response to drug dependence in the UK, was inadequate (The Lancet 1982). The DDUs were confronted with two main difficulties in dealing with heroin addiction in the 1980s.

Firstly, DDUs were under-resourced and under-staffed. Tight controls on public expenditure exercised by the Conservative government meant that spending on the NHS grew very slowly during the 1980s (Ham 2004; Klien 2006). Over the decade, spending on hospital and community health services rose by just ten per cent in real terms (Klien 2006). Those working within the field of drug addiction were not in a good position to compete for resources, which were scarce, as they were traditionally accorded a low priority. Waiting lists for treatment at clinics lengthened which consequently proved as disincentives to those seeking treatment.

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1 The use of an illegal drug plus another legal or illegal drug (EMCDDA, 2002).
Secondly, those drug users who did manage to be seen at a DDU often found that the treatment on offer did not suit them. This was the second major problem encountered by the DDUs: they had failed to adapt to the changing patterns of drug use in the 1980s. Over the course of the previous decade, clinics had stopped prescribing injectable heroin to new addict patients, offering instead methadone. Prescriptions were usually provided over a short period and directed towards total abstinence from drugs rather than indefinite maintenance. DDUs had become inflexible and homogenous and simply unable to cope with the influx of addicts in the 1980s (Mold, 2004); effectively, DDUs were only treating those who were highly motivated to come off drugs.

In an attempt to address these difficulties the Advisory Council on the Misuse of Drugs (ACMD) in *Treatment and Rehabilitation* (1982), called for the ‘development of a range of services to help those with problems arising from the misuse of drugs’. The Central Funding Initiative (CFI) pumped £17.5 million into community-based services between 1983 and 1987 in a direct attempt to shift focus from hospital-based treatment provision, and civil servants actively encouraged a more ‘bottom-up’ approach bringing voluntary agencies, former drug users and even current drug users into the ‘policy community’ (Berridge 1998), hence medicine no longer sat ‘at the top of the table’ (Jaffé, cited by Berridge 1998:93). Changes in drug policy can also be seen through the changed membership of the ACMD, the main expert advisory on drugs policy. In the 1980s it recruited to an originally mainly medical membership, representatives of the voluntary agencies, of health education, social science research, the probation service and of general practice.

The net result of this activity was a dramatic expansion of treatment services. Most of the new money went into community-based services, commonly known as Community Drug Teams (CDTs), with almost 60% going to new community services (voluntary and statutory) and a further 10% going to existing voluntary agencies; most of which were also community based (MacGregor et al. 1991).

The CDT was seen as a significant development during the 1980s and remains prominent in the drug treatment provision of today. They stood then with one foot in the primary health care setting and the other in the secondary service of the District Health Authority or local
authority. Membership was necessarily multi-disciplinary, a specific recommendation of the ACMD (1982) on the basis that this would improve communications with a wider range of health care and welfare professionals. Typically, the CDT of the 1980s comprised between three to six staff with community psychiatric nurses as the most commonly employed group, followed by qualified and unqualified social workers; and most teams had their own secretarial/administrative support staff. The multi-disciplinary teams acted as pass keys opening doors to pre-existing services and facilities. Thus, the rationale for the multi-disciplinary composition of the CDT stems partly from this consultancy goal, as Gilman (1987) describes:

‘It was useful therefore to have a wide range of professions in CDTs so as to assist in “opening up” generic services to drug users. Social workers are more likely to listen to social workers, as GPs are to GPs’.

2.3.3. The re-emergence of public health concerns: HIV/AIDS and harm reduction

From the mid-1980s, as concern rose about the spread of HIV and the potential that injecting drug users might serve as a bridge for infection to reach into the general population (Berridge 1996a), debates about the treatment of drug misuse shifted quite dramatically in focus. The aim to reduce the harm associated with problem drug use, consistent with the advice provided by the Rolleston Committee sixty years earlier, re-emerged as a primary treatment function. In addition, the need for treatment services to act also in the interests of public health became a major priority. The ACMD’s assertion that AIDS was a greater threat to public health than drug misuse meant that prevention of the spread of HIV among injecting drug users accorded more importance than curing them of their addiction (Department of Health and Social Services 1988), and those who had been staunchly opposed to the long-term prescription of drugs to addicts reconsidered their position (Strang 1990). Needle exchanges, providing addicts with clean needles and syringes in return for used ones, sprang up all over England and Scotland, initially as pilot schemes and later as part of the established ‘harm minimisation’ response to drug use (Stimson et al. 1990). And in order to encourage drug users into services, community-based
agencies were provided with a prescribing capability. Methadone became more readily available with many agencies also offering a needle exchange service. Within a framework that was concerned with ‘harm reduction’, abstinence became only the end point in a hierarchy of legitimate and acceptable goals.

The concern about HIV justified an expansion of treatment goals and a change in philosophy, albeit that these had already become unspoken objectives amongst many in the treatment community (Berridge 2002). Treatment services that had previously focused on the therapeutic needs of those drug users who sought abstinence were asked to work to attract into contact those individuals who persisted in using drugs, in an attempt to reduce the harmful consequences of their continued use. As noted above, the notion that treatment could reduce harm to the individual who continued to use drugs was not new (Stimson, 1994), but had become largely overlooked by treatment practice in the preceding twenty years. Neither was the notion that treatment might reduce the wider social and public health harms arising from problem drug use entirely new. Although the aim was not fulfilled, the second Brain Committee had recognised the public health function that treatment might play in containing the spread of drug misuse. However, the 1988 ACMD report was the first time that reducing the harmful social consequences of drug use had received such a visible and vigorous emphasis within drug treatment policy. This new emphasis introduced a climate in which treatment interventions that aim to reduce or contain a range of harms associated with drug misuse were to develop and in which the aim of increasing drug users’ engagement in treatment was to become the key priority. Soon after, following Department of Health guidance, all UK Health Regions established Drug Misuse Databases (DMD) (Donmall, 1990), with the aim to provide epidemiological surveillance of problem drug users who sought treatment.

However, the proliferation of bodies and individuals involved in drug policy and drug treatment both before and after HIV must not be over-stated. As Mold (2004) shows, medicine, and within this hospital-based clinical psychiatry, retained a powerful, and even dominant, role in the shaping of policy towards drug addiction. Through their positions as consultant psychiatrists, DDU doctors were able to acquire expert status in dealing with the
problems of the addict. The claim to expertise undermined the position of the community-based generalist treating addicts and at the same time afforded the specialist a greater role in the shaping of drug policy. The medical practitioner and the medical framework within which to treat drug dependence became, once again, the most appropriate vehicle to reduce the harms associated with drug misuse.

2.3.4. Community safety and crime reduction

During the 1990s, as the HIV/AIDS related health concerns began to recede, the twin issues of community safety and crime prevention emerged, altering significantly the directional flow of policy away from the public health priorities of the previous decade. The ‘drug problem’ referred to during the 1980s was fast becoming a ‘crime problem’ to policy makers and advisors. The ACMD (1991) suggested that, during 1987, approximately 3600 heroin users were committing household burglary, 2900 theft from the person and 5000 shoplifting offence, and a review of literature on the links between drug use and crime (Hough 1996; Stimson, Donaghue, Lart, and Dolan 1990) found that the costs sustained by victims of drug-related crime were substantial, ranging from between £58 million and £864 million pounds.

The high costs of crime associated with drug misuse was highlighted in an independent review of services for drug misusers (Department of Health 1996) concluding that contact with the criminal justice system provided numerous opportunities to engage drug users in treatment (Task Force to Review Services for Drug Misusers 1996). In 1998, the need to safeguard communities was reaffirmed within the UK Government’s ten-year strategy, Tackling Drugs to Build a Better Britain. which set out four primary aims, including: “Communities: to protect our communities from drug-related anti-social and criminal behaviour” (United Kingdom Anti Drugs Coordination Unit 1998). The 1998 strategy was accompanied by an increase in expenditure on drug issues, and claimed that money would be shifted from reacting to drug problems to proactive prevention. The strategy also emphasised partnership approaches to the drug problem, with responsibility for local
delivery of the strategy being given to multi-agency DATs in England and similar bodies in Scotland and Wales.

The main element which distinguished the 1998 drug strategy from the previous loose combination of policy, programmes and funding streams was its focus on the use of treatment and other initiatives to reduce drug-related crime. One of the first initiatives to be implemented was the drug treatment and testing order (DTTO) – community penalties involving treatment and testing elements and supervised by the probation service. Following this, the Criminal Justice and Courts Services Act 2000 was introduced which extended drug testing powers so that it was possible to test for Class A drugs those charged with trigger offences, such as property crime, robbery and Class A drugs offences. Prison-related aims and objectives were also central to the 1998 strategy with new emphases on increasing the number of prisoners in treatment and improving throughcare and aftercare arrangements through the development of CARATS (Counselling, Assessment, Referral, Advice and Throughcare Service).

By the time the strategy was updated in 2002, responsibility for its co-ordination had moved from the Department of Health to the Home Office, where it stands today, which ostensibly had a narrower, crime reduction agenda than the Department of Health. At this time, DTTOs and drug testing in the criminal justice system were proving to be a success (Mallender, Roberts, and Seddon 2002; Turnbull et al. 2000) and many key stakeholders (police, probation, courts, DATs, substance misuse teams) were beginning to recognise that from an individual’s initial contact with law enforcement, to sentencing, to prison or community and re-entry, there were numerous opportunities to focus efforts to improve the response to people with drug misuse problems. As a result, the Drug Interventions Programme (DIP) was introduced which brought together the array of criminal justice interventions and aimed to coordinate treatment for offenders at every stage of the criminal justice process. The DIP was further expanded and strengthened through the implementation of the Drugs Act 2005 which rolled out nationally test on arrest, required assessments, and Restrictions on Bail. Even at the time of writing, DIP remains a major policy programme.
The use and implementation of the Drug Strategy have contributed to the apparent achievements made since 1998 and it is these achievements which the 2008 drug strategy, *Drugs: protecting families and communities*, (HM Government, 2008) builds upon. The difference between this and the previous strategy was its aim to target money and effort where it can make the most difference by ensuring that people are successfully completing treatment and rebuilding their lives. Thus, abstinence and the notion of the ‘recovery’ of the drug user were re-established as primary objectives.

This notion of recovery is echoed in the most recent drug strategy, launched in December 2010 by the Conservative Liberal Democrat Coalition government, which is said to have ‘recovery at its heart’ (HM Government, 2010). Other developments, such as a rapidly emerging recovery movement (e.g. the UK Recovery Federation, Wired In, and The Art of Life Itself), suggests a significant move towards abstinence-based treatment for drug problems.

The promotion of abstinence-based treatment, however, is having a profound effect on the treatment ideologies and role of the drug treatment practitioner. The approaches taken in the UK have been heavily influenced by American experiences and 12-step mutual aid (Bamber, 2010) which have resulted in the promotion of abstinence over and above harm reduction approaches popular in the 1980s. Consequently, “the terms ‘recovery’ and ‘abstinence’ have often been used interchangeably (Laudet, 2007), with ‘harm reduction’ portrayed as an opposite and negative concept” (Neale, Nettleton and Pickering, 2011a: 189). Furthermore, the most recent Drug Strategy’s emphasis on the use of so-called holistic approaches to address issues, such as offending, employment and housing, suggest the beginnings of a shift away from the medical practitioner and psychiatrist led treatment of previous decades.

### 2.4. Conclusion

The purpose of this chapter has not only been to provide the reader with some understanding of how drug policy has developed over the course of the past 150 years, but
also to identify some of the key themes and turning points in the history of drug policy which might provide some insights about how and why the current system of drug treatment operates as it does and often fails to address the needs of so many users of illicit drugs. Certainly, in the absence of further investigation the use of drugs and the responses to it do appear to have changed quite dramatically over the course of the previous 150 years. Moreover, there does seem to have been some attempt by policy makers to respond to the changing needs of individuals who use drugs; this is most certainly evident by the relatively coherent drug strategies and substantial public investment. Nevertheless, this chapter has shown that much of these drug policy changes have occurred under a broad umbrella of policy that has adopted a framework of risk-based strategies to regulate and control drug use. Drug policy, it seems, has become more about regulating and controlling the ‘deviant’ rather than focusing on the needs of the individuals, and it is the potential effects of such a policy direction with which this thesis is concerned.

While this policy direction cannot be disputed I hope that I have demonstrated as have other authors, most notably Seddon (2010), that such a policy focus has not simply unfolded as the use of particular drugs became more dangerous. Rather, this policy focus developed, or at least gained pace, as a consequence of the changing profile of drug use, the drug user and the increasing links that were being made between drugs, poverty, deprivation and, importantly, crime. As it has been shown in this chapter drug users were once viewed sympathetically and seen in need of help and treatment – a notion reinforced by the fact that up until the 1960s, drug users were largely middle class, did not generally commit crime to fund their habit and were treated by their own doctors (Berridge, 1999a). Drug users, however, did not remain within the realms of the middle classes and alarm bells began to ring in the 1960s when recreational drug use expanded. It was against the backdrop of these types of changes that prompted the need to shift the perception of drug use from one which was regarded as a ‘bad habit’ for a minority to one which was regarded as a ‘problem’, and it is this perception that remains at the time of writing. While drug dependency remains a chronic disease to be treated by the medical profession, the pre-occupation of policy makers to protect society from the ‘risks’ and ‘harms’ posed by dependent drug users, particularly in recent years with respect to drug-driven crime, has
meant that such behaviours have legal consequences which must be addressed by the
criminal justice system. Consequently, drug use has become regarded as a medical, legal
and, in some respects, moral issue.

It is in relation to this final point that this thesis investigates further. The two chapters that
follow begin to theorise about the implications of emphasising the medical, legal and moral
aspects of drug taking. Chapter 3 considers these implications with regards to the identity
of the drug user. In this chapter I argue that not only are drug users defined and labelled as
‘sick’ but by engaging in a behaviour which is subject to legal and moral condemnation
they are also defined and labelled as ‘deviant’. Chapter 4 then considers the implications of
emphasising the medical, legal and moral aspects of drug taking on the way in which drug
dependency treatment is delivered. In this chapter I argue that the emphasis that has been
placed on the management and control of ‘risk’, in particular, the PDU – has encouraged a
particular type of working – multi-agency working. The effectiveness of this approach,
however, has been variable, and this chapter seeks to explain why. Drawing on existing
literature and utilising theories from the sociology of health, deviance and organisations,
these chapters will achieve the difficult but vital task of organising a conceptual framework
within which the empirical data presented in Part II will be analysed.
Chapter 3: The labelling of dependent drug use and its effects on drug users

“There is much to be said about modern journalism. By giving us the opinions of the uneducated, it keeps us in touch with the ignorance of our community” [Oscar Wilde, Irish writer and poet, 1854-1900]

3.1. Introduction

Commenting on the changes that occurred during the nineteenth and twentieth centuries, the previous chapter illustrated how drugs have become regulated and controlled, firstly through a process of medicalisation and secondly through a process of problematisation and criminalisation. Drug use has come to be viewed as a social and legal problem and a medical framework has been considered as the most appropriate vehicle in which to address such problems, thus requiring the intervention of both medical and criminal justice specialists. Dependent drug use is, on the one hand, a chronic and relapsing condition characterised by relapses requiring longitudinal care, but on the other is considered a problematic behaviour whereby the user is regarded as deviant.

This chapter argues that as a consequence of this dichotomous view of drug use and the drug user, dependent drug users are labelled as both ‘sick’ and ‘deviant’. Consequently, the extent to which they are or are not responsible for their condition remains in contention. The user’s ‘drug dependence’ status allows them to enter the ‘sick role’ whereby responsibility for the illness should be removed (Parsons, 1951). Simultaneously, however, dependent drug users are viewed as engaging in a behaviour which is subject to both legal and moral condemnation. Hence, they are held responsible for their condition.

Through a review of the theoretical and empirical literature the aim of this chapter is to examine the likely implications of these labelling processes, particularly on the identity of
the dependent drug user. After examining the public discourse surrounding drug use this chapter will draw on two perspectives which have dominated the sociology of health and illness: the functionalist and interactionist approaches. The functionalist approach highlights the extent to which illness can involve the adoption of an appropriate social role – the sick role. The interactionist approach, by contrast, focuses on the person who is ‘ill’, how those around them make sense of the illness, and how these interpretations might affect behaviour. The interactionist approach to illness was formulated through critiques of the functionalist approach so it is logical to take the two in turn. The chapter will end with an examination of the effects of being illegitimately labelled as ‘sick’, and the reinforced status of ‘deviant’, on a dependent drug user’s notion of self and identity (Goffman, 1963).

3.2. Public discourse and drug use

Alongside the drug policy changes observed in Chapter 1 there have been changes in the public discourse surrounding drug use. This section examines such discourse and considers its implications for the identity of the drug user.

Over the course of the previous 150 years, or at least since the inception of the Pharmacy Act, 1868, the UK has observed changes in general patterns of drug taking. During the late nineteenth century, and into the early twentieth century, drug users were mainly therapeutic addicts, who had become dependent during the course of pain killing treatment with opiate-type drugs, medical professionals, who had abused their access to opiates, and recreational users of illegal drugs – the latter were relatively few in number but included those on the bohemian fringes of high society (Bewley, 1966; Hawks, 1970). From the beginning of the 1950s, however, there were some indications that the existing pattern of middle-class opium and morphine addicts was beginning to change. It has been suggested (Spear, 1969; Spear 2002) that a significant contributory factor of this change was the distribution, during 1951, of heroin, morphine and cocaine, obtained from a single large hospital theft, amongst a group of hitherto naïve individuals. This group was said to have “formed the nucleus of a heroin addict population which was to expand gradually but inexorably over the next few
years” (Spear 2002). In contrast with the older addicts of therapeutic origin, the new addicts sought excessive supplies from a few doctors who were prepared to prescribe generously, distributing the surplus in, and thus fuelling, “a growing commercial illicit market” (Spear 2002). Many were jazz musicians or regular visitors to jazz clubs where heroin, cocaine and cannabis were regularly used. As observed by Yates (2002:5):

‘Public opinion, steered by the media… was ripe for reaction to the flood of drugs epidemic stories which began to appear with increasing frequency in the late 1950s and early 1960s. In the 1920s it had been the dilettante rich, now it was the wayward youth. Emerging was a new type of user – young and working class. They wore different clothes; they listened to ‘jungle music’ and had a distinct disrespect for the attitudes and ideals of their elders’.

Nevertheless, drug use remained, at this point, a largely unproblematic phenomenon. In the early 1980s, however, when illegal drug use became epidemic in large cities and urban communities (amongst the unemployed working class youth) it shocked society (Yates, 2002). Heroin, the main drug of choice, had become a serious social problem affecting many large UK cities (Pearson, 1987). A prominent discourse, particularly in the international arena, was the enforcement focused language and tactics of the so-called ‘war on drugs’ (Buchanan and Young, 2000). Announced initially by President Nixon in the 1960s, and renewed by President Reagan and the UK Prime Minister Margaret Thatcher in the 1980s, the rhetoric of both US and UK governments – and a substantial element of policy and practice also – involved attempts to control drugs through enforcement initiatives. As a consequence of such enforcement rhetoric, young heroin addicts were portrayed as unkempt social outcasts who threatened the cohesion of local communities and placed lives at risk. The identity of the drug user had changed, from one of middle class origin which occasionally smoked opium as a past time to one which was young, working class and threatened the fabric of society (Buchanan and Young, 2000).

This portrayal of drug users, however, has not been limited to Government rhetoric. Historically, there has been an abundance of academic interest into the representation of illicit drug use by the media. Becker (1963) showed how marijuana users in the 1960s were labelled as ‘outsiders’ and drew attention to the media for their role in this process.
Additionally, Downes (1977) insisted that the media portray the drug user as a ‘folk devil’, while Critcher (2003) demonstrated how the media influenced the response to rave culture and ecstasy, creating what some have termed a ‘moral panic’. Many of these accounts, according to Murji (1998:69, emphasis in original) follow a similar line:

“The dominant, conventional approach has seen the media as a key force in the demonization and marginalisation of drug users, as presenting lurid, hysterical images and as a provider of an un-critical platform from which politicians and other moral entrepreneurs are able to launch and wage drug ‘wars’. The media is thus seem to comprehensively mis-represent drugs, their effects, typical users and sellers and indeed the whole nature of the drug market and the enforcement response to it. In many ways the media may even define what we ‘see’ as drugs because it concentrates on solvents, heroin, crack, ecstasy, etc....thereby conditioning public attitudes about the ‘drug problem’ and what the response to it should be. Furthermore, media coverage is not just misleading it can also actually be harmful because it is implicated in the triggering of drug scares and moral panics which lead to ‘knee jerk’ drug crackdowns and punitive responses”.

Drug use crosses all social demographics (Buchanan, 2006), yet the images that are generated from drug policy and the mainstream news media do not adequately represent this and instead focus on convenient stereotypes. The negative and stereotypical representations of drug users (particularly heroin and crack cocaine users) as criminal outsiders and a threat to middle class sobriety and the fabric of mainstream society, are common features of media reports. While the image of drug users in the media varies across different media sources (Blackman, 2004; Manning, 2007), there is undoubtedly a dominant stereotypical image, echoed by the popular mass media, that has emerged, prevailed and been sustained within the reporting of national and local news over the last three decades (Elliot and Chapman, 2000; Lancaster, et al. 2011). Drug use, for example, is often portrayed in the media as the key causal factor in many crimes: ‘Drug addict daughter of famous playwright jailed after killing son with methadone’ (Daily Mail, 2007); ‘Drug addict who killed his three month old son by throwing him down the stairs is jailed for life’ (Daily Mail, 2009). This imagery not only influences public opinion about illicit drug users and the risks they pose (Blood, et al. 2003) but also reinforces the belief that there is a causal link between drug use and crime, and the use of legal sanctions to try to control this risk has further strengthened this image (Taylor, 2008).
As a consequence of the discourse surrounding drug use, the use of drugs in any circumstance has been regarded as dangerous and harmful, not only to the individual but to society in general (Cunningham, 1998). Illicit drug taking has been presented as an ‘enemy’ within, that can, and will, be eradicated, reinforcing dominant and stereotypical images of drugs, drug users and drug-related crime (Buchanan, 2000). Both the official and public discourse towards drugs is that they are ‘bad’, and the use of drugs represents a behaviour which only the ‘other’, or indeed, ‘deviant’ engages in. As a US discussion put it, ‘in spite of two centuries of claims that addiction is a disease, and more recently that it is similar to other chronic diseases, the idea that addiction is rooted in repeated bad choices remains widely compelling’ (Baumohl, Spe glm an, Swartz, and Stahl, 2003). Addiction is, on the one hand, a category in the international classification of health disorders, under its professional name of drug dependence, and on the other, a thoroughly moralised and derogated type of behaviour.

3.3. The sick role: Legitimising deviancy?

Despite the apparent problematisation of drug use illustrated in the previous section, the disease model of addiction has continued to dominate drug treatment policy. This approach has remained dominant not only because ‘drug addiction’ has been described as a chronic and relapsing condition (NTA, 2002), but because drugs and drug users pose potential problems which require governmental action, and medical practitioners have become the most appropriate people through which this action can be delivered (Seddon, 2011:33). It is possible to argue, therefore, that upon being diagnosed as drug dependent, drug users are assigned to the ‘sick role’. The extent to which this role legitimises dependent drug users’ otherwise deviant behaviour, as it does for other illnesses, however, has long been disputed (Roman and Trice, 1968; Blackwell, 1967; Friedson, 1970; Lesser, 1974). This section, therefore, not only introduces the concept of ‘sick role’ but also examines the extent to which it applies to the dependent drug user.
The model of the sick role, developed by Talcott Parsons in the 1950s, was the first theoretical concept that explicitly concerned medical sociology. In contrast to the biomedical model, which constructs illness as a mechanical malfunction or a microbiological invasion, Parsons described the sick role as a temporary, medically sanctioned form of deviant behaviour. Using ideas from Freud’s psychoanalytical theories as well as from functionalism and Max Weber’s work on authority, Parsons created an ‘ideal type’ that could be used to shed light on the social forces involved in episodes of sickness. Sickness, according to Parsons (1951:112), is a form of deviance and involves a recognition of the

“Impairment of the individual’s capacity for effective performance of social roles and of those tasks which are organised subject to role expectations”

Therefore, norm violations are prescriptively or retrospectively explicable in the context of sickness.

Moreover, according to Parsons (1951:113), the ‘traditional’ sick role has certain characteristics. Firstly the ‘sick role’ is a “partially and conditionally legitimated state in which others are expected to treat the sick person with compassion, support and help”. Secondly, it forms “the basis of a series of legitimised exemptions from the fulfilment of normal expectations” in relation to everyday social obligations and relationships (for example, an inability to work, an inability to maintain a good relationship with others). Thirdly, by reason of the incapacity, “the individual is not held responsible for his state, in the sense that he could be expected to become well through ‘pulling himself together’ by an act of will”. Finally, the sick role has “a definitely ascribed goal of action...namely to ‘get well’” through active co-operation within a therapeutic regime. Thus, a person who is sick cannot be expected to fulfil normal social obligations, and is not held responsible for their illness. In turn, however, the sick role assumes that the sick person should want to get well, and to this end, must seek and cooperate with medical help. The sick role indicates that the person who makes an effort to get well will be granted a social status, as Herzlich and Pierret (1987:53) explain:
“To be sick in today’s society has ceased to designate a purely biological state and come
to define a status, or even a group identity. It is becoming more and more evident that we
perceive the reality of illness in these terms, for we tend to identify our neighbour as ‘a
diabetic’, almost in the same manner as we identify him as ‘a professor’, or ‘a mason’. To
be ‘sick’ henceforth constitutes one of the central categories of social perception”

Thus illness may become part of the identity of the sufferer, and this is especially
significant, as this thesis will show, for those labelled as drug dependent.

Various arguments have been put forward about the implications of the assignment of the
sick role to the dependent user. Roman and Trice (1968) in their examination of deviant
drinkers suggest that the use of a disease model, as seen in the treatment of dependent drug
use, has led to the assignment of the labelling function to medical authorities, which in turn
has led to the placement of alcoholics and deviant drinkers in ‘sick roles’. The expectations
surrounding these sick roles, they argue, serve to further develop, legitimise, and in some
cases even perpetuate, the abnormal use of alcohol; an argument which could also be
applied to dependent drug users.

Roman and Trice argue that there are two basic mechanisms operating through the medical
labelling process, which is based on the disease model of drinking, that may serve to
reinforce deviant drinking behaviour. The first mechanism is the assignment of the sick
role. Being labelled by a physician as manifesting illness, they argue, may legitimise
deviant drinking patterns since these patterns have been labelled results of pathology rather
than deviant behaviour. This is due to the fact that one of the main characteristics of the
sick role is that the individual is not held responsible for their illness; thus, in the case of
abnormal drinking behaviour, the assignment of the sick role removes the individual’s
responsibility for engaging in this behaviour, encouraging further abnormal drinking
behaviour.

The second mechanism relates to the labelling process – being defined as an ‘alcoholic’.
This process, Roman and Trice argue, may lead to secondary deviance through a change in
an individual’s self-concept as well as a change in the image or social definition of him by
significant others (Becker, 1963). The individual with the medical diagnosis of ‘alcoholic’
occupies a social status which has accompanying role expectations, the principal expectation being engagement in deviant drinking practices. Deviant drinking behaviour is, therefore, legitimised through the disease label in the sense that the individual is no longer held responsible for their behaviour. Simultaneously, the individual is expected by significant others in their life space to ‘shape up’, seek treatment, and above all, stop drinking. However, both this message and the message of being ‘sick’ appear legitimate but contradictory.

The arguments put forward by Roman and Trice have also been applied to dependent drug users. Lesser (1974) examines how the placement of the addict in the ‘sick role’ suggests conflicts in the definition of illness as ‘legitimate deviancy’ or escape. In other words, by placing the addict under medical control, we are, according to Lesser, placing him in a more socially acceptable role. The placement of addicts in a more acceptable role of patient is not helping them but hindering them by allowing them to remain deviant in a more docile form. Methadone maintenance, according to Lesser rewards addicts by giving them the drug and thus legitimising their ‘need’ for it.

More recent studies have argued that placing individuals in the ‘sick role’ is detrimental to recovery. Pearce and Pickard (2010) argue that the sick role allows patients to be passive victims of disease. As a consequence, the authors argue, dependent drug users do not believe that it is in their power to change and cannot rationally decide or resolve to do so, thus locking individuals further into their addiction.

However, as important studies conducted in the mid-1980s suggest, dependent drug users are far from passive victims of addiction. As Auld et al. (1986:172) illustrate, addiction requires drug users to be active within an irregular economy which may include ‘intensive periods of work (buying, selling, contacting, getting money together, etc.). In between these intensive bursts of activity the business of survival requires one to be always searching for further opportunities, and to be on the look-out for potential dangers’. Moreover, in Pearson’s (1987:83) study, becoming a successful user-dealer was also a means for some to achieve a level of status and identity in the neighbourhood as somebody worth knowing and with ‘real local standing’. By giving a meaningful daily structure, based around this
prolific activity in the irregular economy, the emptiness and disorientation sometimes associated with the absence of the daily routines of work could be avoided:

“Heroin use within the contexts of unemployment can take on a new significance, as an effective resolution of the problem of de-routinised time-structures. Dependence on heroin, quite literally, imposes its own rigid time-structure involving a necessary cycle of events… the rhythm of a heroin user’s day was often described as if it were dictated by the beat of a metronome, of getting up, jostling for money, buying heroin, smoking it, and then hustling for the next bag” (Pearson, 1987:87)

Thus, as Preble and Casey (1969:3) argue, ‘the quest for heroin is the quest for a meaningful life’. This quest, they suggest does not lie in the effects of the drug but ‘in the gratification of accomplishing a series of challenging, exciting tasks, every day of the week’.

This is not to suggest that their ‘activeness’ should allow for recovery. On the contrary, as the empirical data presented in Part II will demonstrate, occupying the sick role could provide an alternative form of meaning. Thus, actively seeking to remain in the sick role could potentially inhibit their chances of recovery.

Despite the potential drawbacks of assigning dependent drug users to the sick role the disease model continues to dominate the treatment of addictions and there is a legitimate reason for this. The general perception, in the US context in particular, has been that more stigma is associated with crime or vice than with disease (Room, 2005). This viewpoint, tending to come from doctors and psychiatrists, sees the choice as a simple one: either addiction is a moral issue, involving ‘voluntary, self-inflicted and immoral behaviours’ (Blume et al, 1996:853), which is then stigmatised and treated punitively through the criminal justice system, or it is a treatable disease of the brain, requiring a medical response. In other words, treating drug dependence as a disease will reduce the stigma associated with drug using behaviour.

However, as Leshner (1997:46) suggests, addiction is not simply a disease of the brain, ‘it is a brain disease for which the social contexts in which it has both developed and is expressed are critically important’. The illicit use of drugs has both moral and legal
consequences and some researchers have even suggested that users of illicit drugs are often viewed as ‘less deserving because their need resulted from addictive life choices rather than the perils of random health failure’ (Simmonds and Coomber, 2009:125). This argument is similar to that put forward by those who have studied mental health. Blackwell (1967) explored adult expectations about entering the sick role for physical and psychiatric conditions and reported that the rights and obligations of the sick role (as described by Parsons) apply directly to the physical, but not to the psychophysical and psychosocial conditions. A major finding of this study was that the extent of societal agreement about admission to the sick role decreases as the social and psychological aspects of the condition increase. Thus, as with those who are suffering a mental health condition, the deviant behaviour of a dependent drug user is not legitimised through access to the sick role and neither are the rights and privileges of the sick role likely to be granted (Friedson, 1970). Dependent drug users, therefore, remain ‘deviant’.

3.4. Labelling: The reinforcement of deviance

According to the interactionist perspective, the status of the dependent drug user as ‘deviant’ has implications for an individual’s future actions, self concept and relationships with others. Becker, who wrote extensively on the effects of becoming labelled as deviant, issued one of the most influential statements relating to ‘labelling theory’ (1963:9):

“Social groups create deviance by making the rules whose infraction constitutes deviance and by applying those rules to particular people and labelling them as outsiders. From this point of view, deviance is not a quality of the act the person commits, but rather a consequence of the application by others of the rules and sanctions to an ‘offender’. The deviant is one to whom the label has successfully been applied; deviant behaviour is behaviour that people so label”.

Becker is suggesting here that in one sense there is no such thing as a deviant act. An act only becomes deviant when others perceive and define it as such.
Becker’s most famous essay, ‘Becoming a Marijuana User’, illustrates his argument that deviant ‘motivation’ (why we decide to do things that are socially proscribed) is often developed in the course of experience with that deviant activity. Becker (1963:42) argues that “instead of the deviant motives leading to the deviant behaviour, it is the other way around; the deviant behaviour in time produces the deviant motivation”. This process is also captured by Merton’s (1968) term, ‘self-fulfilling prophecy’. This term, he described, as “in the beginning, a false definition which makes the originally false conception come true” (1968:477). Much labelling theory, therefore, proceeds from the premise that many offenders are falsely defined as such or, if not falsely defined, have their moral character degraded as well as their behaviour judged. Put crudely, not only is their behaviour defined as ‘bad’, but their character too. Judged as being bad, and labelled as such, there is an enhanced likelihood that this will become that person’s master identity or will promote behavioural choices which predispose toward increased criminality in the future. The possible effects on an individual being publicly labelled as deviant are numerous. A label defines an individual to themselves and to the outside world as a particular kind of person. A label is not neutral, it contains an evaluation of the person to whom it is applied. It is a ‘master status’ in the sense that it colours all the other statuses possessed by an individual. Becker (1963) noted that if an individual is labelled as criminal, mentally ill, or addicted, such labels largely override their status as parent, worker, neighbour or friend. Others see the person and respond to them in terms of the label and tend to assume they have the negative characteristics normally associated with such labels. Since an individual’s self-concept is largely derived from the responses of others, they will tend to see themselves in terms of the label. This may then produce a self-fulfilling prophecy whereby ‘the deviant identification becomes the controlling one’ (Becker, 1963:34). For example, though the effects of drugs may not impair one’s working ability, to be known as an addict may lead to losing one’s job. In such cases, individuals may find it difficult to conform to other rules which they had no intention or desire to break, and finds himself deviant in these areas as well. Dependent drug users, for example, may become compelled to engage in other illegitimate kinds of activity, such as robbery and theft, by the refusal of respectable employers to have them around. This behaviour, according to Becker (1963:35), ‘is the consequence of the public reaction to the deviance rather than a
consequence of the inherent qualities of the deviant act’. Put more generally, the treatment of deviants denies them the ordinary means of carrying on the routines of everyday life open to most people. Because of this denial, the deviant must, out of necessity, develop illegitimate routines.

There is another possible consequence of labelling which may occur and serve to further ‘lock in’ deviant drug using patterns. As a result of the process of rejecting the individual from group associations that may result from the presence of the label as well as from intolerance of their deviant drug using, the illicit drug user may seek opportunities to affiliate with more tolerant drug using groups (Sutherland, 1924; Philips, 1963). This differential association serves to further legitimise, reinforce, and perpetuate illicit drug use and lead further toward patterns of addiction.

So far this chapter has demonstrated that drug dependence is considered both a disease entity and a deviant behaviour. Due to its disease definition, drug dependency remains an issue to be dealt with by the medical profession, who consequently grants the dependent drug user access to the ‘sick role’. In contrast to other chronic and relapsing conditions, however, drug dependency has become highly problematised. As a consequence, the ‘sick role’ fails to legitimise the deviancy of drug dependency. Dependent drug users, therefore, remain deviant and their access to the ‘sick role’ is regarded as illegitimate reinforcing, stigma, marginalisation and social exclusion, the subject of the following section.

### 3.5. Stigmatisation, marginalisation and social exclusion

Before examining the extent and implications of a stigmatised identity among dependent drug users it is firstly necessary to explain what is meant by stigma. The word stigma originated with the ancient Greeks, who physically marked individuals who were deemed undesirable with brands, indicating that these individuals were to be avoided (Goffman, 1963). This meaning of stigma has been expanded to include any mark or sign of a perceived deviation from the norm (Jones, et al. 1984). According to Crocker et al
‘a person who is stigmatised is a person whose social identity, or membership in some social category, calls into question his or her full humanity – the person is devalued, spoiled or flawed in the eyes of others’. Jones et al (1984) have defined a social stigma as being a discrediting condition that marks a person as, ‘deviant, flawed, limited, spoiled, or characteristics are labelled, and these labelled persons are linked with negative stereotypes’ (Fortney, et al. 2004).

A stigma is usually attached to undesirable qualities, and a defining immediate reaction to stigma is avoidance of the stigmatised person (Pryer, et al. 2004). Stigmatised individuals regularly encounter prejudice and discrimination (Shih, 2004). Some have argued that stigma has evolutionary origins, whereby humans possess cognitive adaptations that cause them to avoid poor social exchange partners, resulting in the social exclusion of stigmatised persons (Kurzban and Leary, 2001).

The attribution-emotion model of stigmatisation suggests that emotional reactions such as anger or pity may be derived from attributions made about stigma (Weiner, et al. 1988; Schwarzer and Weiner, 1991; Weiner, 1996). If the stigmatised individual is not considered to be responsible for the onset of the stigma (e.g. in the case of a physical disability), then bystanders are more likely to have a reaction of pity. If the stigmatised individual is deemed to be responsible for the onset of stigma (e.g. in the case of addiction), then bystanders are more likely to have reactions involving anger or irritation, and are less likely to offer help (Weiner, et al. 1988).

There is little doubt that illicit dependent drug users face stigma in its various forms. Link and colleagues (2004) distinguish between three forms of stigma experienced by drug users: enacted, perceived and self-stigma. Enacted stigma, or what might otherwise be described as ‘stigma from external sources’, refers to directly experienced social discrimination such as difficulty in obtaining employment, reduced access to housing, poor support for treatment, or interpersonal rejection. Such stigma can also be manifest in medical clinicians not wanting to spend time dealing with drug issues or can lead to a lower perception of providers who work in this field (Samet, et al. 2001). This level of stigmatisation was recognised by Jeffrey (1979) who distinguished between ‘good’ or
‘interesting’, and ‘bad’ and ‘rubbish’ patients. The ‘bad and rubbish’ patients, he explained, were the trivia, drunks, tramps and overdoses ‘who are seen as deviant, in that they are given a unflattering label, are seen to break rules, and are liable to punishment’ (1979:104), implying that those who make illegitimate claims to the sick role are deviant. Also, in a review of studies from the 1980s and 1990s, McLaughlin and Long (1996:283) concluded that ‘the majority of health professionals hold negative, stereotypical perceptions of illicit drug users’. Perceived stigma and self-stigma are terms that have been used to describe how members of the stigmatised group feel about themselves and others around them, and could also be described as ‘stigma from internal sources’. Perceived stigma refers to beliefs that members of a stigmatised group have about the prevalence of stigmatising attitudes and actions in society (Link, et al. 1989). Self-stigma refers to the negative thoughts and feelings (e.g. shame, negative self-evaluative thoughts, and fear) that emerge from identification with a stigmatised group and their resulting behavioural impact (e.g. avoidance of treatment, failure to seek employment, avoidance of intimate contact with others).

The effects of such stigmatisation have been well documented within the mental health field. For example, enacted stigma is associated with multiple negative outcomes such as unemployment (Link, 1987; Penn and Martin, 1998), housing problems (Page, 1983) and difficulty in social adjustment (Perlick et al. 2001). Self-stigma in the seriously mentally ill has been associated with delays in seeking treatment (Kushner and Sher, 1991; Scambler, 1998; Starr, Campbell, and Herrick, 2002), diminished self esteem/efficacy (Corrigan and Watson, 2002), withdrawal and social isolation (Dunion and McArthur, 2011) and lower quality of life (Rosenfield, 1997). Importantly, it has been suggested that the stigma that exists in society – enacted stigma – helps to generate and perpetuate self-stigma. According to Dunion and McArthur (2011) the negative attributes associated with mental ill health are sufficiently strong as to have become self-evident ‘truths’, which influence the beliefs and attitudes of individuals with mental health problems. Self-stigma is subsequently defined as ‘a process whereby a person with a mental health problem is aware of public stereotypes of mental health problems or mental illness and in a implicit manner applies these stereotypes to himself/herself resulting in low self-esteem and lack of hope’ (2011:i). Indeed, the work on mental health is more advanced than the work on dependent drug use. However, Luoma
et al (2007) recently reported that patients of drug treatment believed that stigmatising attitudes and behaviours towards dependent drug users were common. Similarly, Eley (2007) reported that being/having been a dependent drug user was felt to be a difficult hurdle to overcome, especially for those searching employment; a hurdle which she argues is reinforced by welfare professionals. All the participants in Eley’s study were aware of the perceived lack of trust from employers surrounding them, and how they are perceived negatively, particularly in connection with their drug use. Experiences of external and internal stigma, therefore, appear to be mutually reinforcing. The negative judgements experienced by dependent drug users do not aid or drive an individual away from drug use. Instead, it is possible that such individuals begin to accept or internalise the stereotypical ‘junkie’ identity affecting their sense of well-being, self-esteem and motivation to seek treatment or help in other aspects of their lives.

Not only do dependent drug users have to deal with the stigma associated with being a drug user, they also need to deal with the stigma associated with their mental health, offending, housing and employment problems (Hartwell, 2004; Karpati, et al., 2003 cited in Young, et al. 2005). Such stigma has been found to be significantly associated with poor mental health, depression, and a number of chronic physical health conditions (Young, et al. 2005). It has also been shown that people who experience discrimination due to multiple attributes may have poorer health than those who experience discrimination due to one attribute (Krieger and Sydney, 1997; Landrine, et al. 1995).

There are also structural and institutional processes which are believed to reinforce the stigmatisation of drug users. Some have suggested that campaigns such as the ‘War on drugs’ may inadvertently increase the stigma associated with drug dependence, by reinforcing the negative aspects of drug use. Buchanan and Young (2000) drew upon three qualitative studies involving 200 problem drug users across Merseyside to demonstrate how British drug policy has acted to legitimise and reinforce discrimination against problem drug users. The authors argue that those users who are dependent on drugs such as cocaine and heroin are stigmatised and kept isolated within drug sub-cultures, preventing recovery by hindering their reintegration into the wider society, a situation which is reinforced by drug policy which is concerned with prevention, prohibition and punishment.
In a later study, Buchanan (2004) argues that the ‘war on drugs’ has had implications on the way drug users see themselves, their relationships within their families, and with wider communities, a point which was also emphasised by Room (2005). The discourse dominated by notions of fear and war, Buchanan (2004:394) argues, ‘inevitably leads to an underlying strategy concerned with punishment, control, and exclusion of drug users, rather than care, rehabilitation and inclusion’, resulting in ‘widespread discrimination so that in addition to overcoming a drug problem, one of the biggest hurdles problem drug users face is breaking through the barrier of social exclusion, prejudice and discrimination’. The constant experience of this marginalisation, Buchanan explains, has led many drug users to internalise their problems and blame themselves for their plight. This loss of self-esteem then becomes a serious debilitating factor as they feel isolated and excluded from society.

For many drug users relapse is not simply the result of physical craving or a lack of motivation but a direct consequence of a frustration and inability to secure a position in normal community life and establish everyday routines (Buchanan, 2004). To be a dependent drug user is to have a status that significantly affects relationships and interactions with others; ‘it is a status that obscures all others, and it is a status that frequently incites disgust, anger, judgement and censure in others (Lloyd, 2010:65). The demonisation of problem drug users makes it unlikely that individuals and agencies will ‘give them a chance’ and as a result they find themselves regularly shunned and excluded. At the very time when recovering drug users need assistance and support from the non-drug using population to establish alternative patterns of social and economic life, they are often prevented by the so-called ‘wall of exclusion’ (Buchanan 2004:395).

Drucker (2000: 31) suggests that the repercussions they face as a result of demonization and criminalisation could be a greater threat than the dangers posed by the drugs they take:

“In an environment frightened with powerful moral and legal reactions to the use of drugs, the stigma attached to drugs may come to be a more important factor than the biology of addiction. The demonization of drugs and the criminalisation of the drug user (i.e. the war on drugs) could be more damaging to the individual and society than drug use or addiction”.
To overcome addiction, therefore, dependent drug users must manage the identity which has been associated with them (Biernacki, 1986; Waldorf, 1983). According to Biernacki (1986), the decision to stop taking drugs comes about when the user’s addict identity conflicts with, and creates problems for, other identities that are unrelated to drug use – such as those of a partner, parent or employee – in ways that are ultimately unacceptable to them. For Biernacki (1986), the key to the recovery process lies in the realisation by the addict that their damaged sense of self has to be restored together with a reawakening of their old identities and/or establishment of new ones.

More than a decade later, McIntosh and McKeganey (2001) emphasised the importance of individuals to construct a non-addict identity. Consistent with Biernacki’s findings, McIntosh and McKeganey argued that this required drug users to realise that they were exhibiting characteristics that were unacceptable to themselves and to their significant others, and that their identity had been ‘spoiled’. According to McIntosh and McKeganey (2001), processes of identity reparation were evident in individuals’ efforts to distance themselves from illegal drug use; distinguish between the person they believed themselves to be at heart and the person they felt they had become because of their drug use. In an attempt to manage their ‘spoiled identity’ it has been found that drug users frequently seek to divorce themselves from a negative drug user identity. This practice involves individuals denigrating, or comparing themselves favourably with, other drug users, contrasting the good person they are now with the bad person they were whilst using; or distinguishing between the addict within themselves and the ordinary person they really are (Best, et al. 2007; Radcliffe and Stevens, 2008).

However, as Neale and colleagues (2011b:4) quite rightly point out, the approach taken to manage a stigmatised identity ‘seems somewhat derogatory as it implies that the stigmatised identity is a more totalising identity from which it can be difficult to escape’. In an effort to shift away from this approach Neale and colleagues (2011) suggest that Goffman’s broader work on dramaturgy might be helpful. Dramaturgy is also helpful when trying to explain the process of labelling particular behaviours or individuals as deviant. As Rock (1973:66) states, deviance
“is rarely an alien label which strikes the unprepared innocent from afar. The process of becoming deviant is a vastly more complex negotiation of identities and consequences which takes place in an endless series of mundane contexts”

Dramaturgy (Goffman, 1959) analyses social interaction as if it were part of a theatrical performance. Thus, identity is perceived as something that is ‘done’ rather than ‘owned’ and the focus is on what individuals ‘do’, rather than who they are. As Goffman (1959: 252) suggests:

“The self itself does not derive from its possessor, but from the whole scene of his action…the self is a product of a scene that comes off, and not a cause of it. The self, then, as a performed character, is not an organic thing that has a specific location… [the individual and his body] merely provide the peg on which something of collaborative manufacture will be hung for a time. And the means for producing and maintaining selves do not reside inside the peg”.

Goffman argues that an individual’s identity arises in the process of performance. Such performances, he suggests, are conveyed by two distinct modes of communication: ‘expressions we give’ and ‘expressions we give off’. ‘Expressions we give’ are primarily the things we say and are often conscious and intended, whereas ‘expressions we give off’ are those elements of our expressions over which we have less control and are, therefore, often unintended. When in the presence of others, therefore, a person is a ‘field of expression for them to read’ (Rock, 1973:68). These expressions constitute ‘general style, posture, facial movements…clothing’ and so on (Rock 1973:68) and are referred to by Goffman (1959) as ‘personal front’. Less fixed than apparel, this general demeanour is constantly adjusted by those in the encounter in response to a series of symbolic gestures. Moreover, the terminology ‘expressions given off’ (Goffman 1959) is not only inclusive of ‘glances, gestures and positionings’ (Goffman, 1967:1) but also the setting in which the interaction takes place. The minutiae of encounters as diminutive social worlds cannot, therefore, be communicated adequately through the significant symbol of language alone, and language may conceal more than it reveals, and so there is left an absence of social facts. As Goffman (1959) points out, a person’s ‘innermost feelings’ are not or will not necessarily be available during the course of the encounter and may only be inferred from ‘predictive devices’ of ‘cues, tests, hints, status symbols’ and so on. Knowing that
individuals are likely to express themselves in a light that is favourable to them, Goffman (1959: 18) suggests that the ungovernable aspects of an individual’s expressive behaviour (i.e. the expressions given off) are used to check upon the validity of the governable aspects (i.e. the expressions given). In order to project a sense of honesty and integrity, therefore, it is important for individuals to seek to maintain congruence between the expressions they ‘give’ and the expressions they ‘give off’.

There are, however, times when the expressions that are ‘given off’ contradict the expressions that are given. Expressions by dependent drug users to become drug free, for example, may not be supported by their apparent behaviour when in treatment which suggest a lack of desire to get well, lack of internal motivation to seek treatment, and when in treatment a failure to comply. Such expressions or behaviour may, according to Goffman (1959:23), ‘discredit, or otherwise throw doubt upon [an individual’s] projection… At such moments the individual whose presentation has been discredited may feel ashamed while the others present may feel hostile’. To adapt Goffman’s (1959) dramaturgical terminology, the person plays a part that does not come off.

Maintaining symmetry between the expressions that are given off and the expressions that are given can prove particularly problematic for someone whose drug taking is chaotic (Neale, et al. 2011b:6), resulting in what might be inaccurate conceptions of an individual’s character and/or intentions. Goffman (1959) believes that first impressions, that is, ‘the information that the individual initially possesses or acquires’, are crucial. Conversely, therefore, it is imperative that one starts as one means to go on in establishing a definition of the situation (Goffman, 1959). However, entering drug treatment as a consequence of external pressures and coercion, as many dependent drug users do (Marlowe, et al, 1996; Bean, 2004), suggests a lack of internal motivation to ‘get well’ and it is on this basis that a person starts to define a situation and starts to build up lines of responsive action (Goffman, 1959). Although this initial impression may be modified as the interaction progresses the tendency is that it is largely sustained (Goffman, 1959). Such personal fronts also give rise to abstract and stereotyped expectations based on past experience (Goffman, 1959), including that possessed by the individual in the form of the ‘generalised other’. Some deviant roles, particularly those of a heroin and/or crack cocaine
‘addict’, are well known figures within societies, even serving an ‘educative purpose’ as ‘folk devils’ (Rock, 1973:34). These are characters, existing predominantly in the imagination rather than in the course of everyday life, about whose qualities there is consensus (Turner, in Rose, 1962:30), that people tend to know in some depth and so may impute to and expect from a person so categorised a whole range of behaviours. Once a social role has been attributed, signs that confirm this status may be sought out, and signs that appear to cast doubt upon it may be denied or reinterpreted.

Adopting Goffman’s dramaturgical framework, therefore, to analyse the data presented in Part II may help to provide further insight about why dependent drug users often find it difficult to escape their negative ‘addict’ and ‘deviant’ identity.

3.6. Conclusion

Central to this chapter has been the issue of ‘responsibility’. Due to the disease status of drug dependency, dependent drug users should be excused from the normal expectations in relation to everyday obligations and should not be held responsible for their condition. Access to the ‘sick role’ should thus legitimate their deviancy. Through changes in drug policy, the increasing alignment between medicine and the criminal justice system (observed in Chapter 2), and the official and media discourse surrounding drug use (observed in this chapter), dependent drug users are, instead, held responsible for their addiction. Their access to the sick role is thus regarded as illegitimate and their deviant status remains.

What was once considered a behaviour associated with the middle classes is now regarded as a ‘problem’ associated with the working classes who threaten the fabric of society. The label, therefore, attached to dependent drug users is one of both legal and moral condemnation. The literature examined in this chapter suggests that this label firstly, threatens to become the individual’s master identity, and secondly, promotes choices and behaviours which predispose the individual toward increased drug use in the future.
Furthermore, the negative connotations associated with drug use are said to affect the responses of individuals who have a role to play in the treatment of the dependent drug user. Due to the demonization of drug use, individuals and agencies frequently shun and exclude drug users at a time when they are needed most. Consequently, relapse becomes likely with drug users often feeling frustrated, unable to secure a position in normal community life and unable to establish every day routines.

While this chapter has gone some way to examine how the construction of, and responses to, drug use have affected the identity of the dependent drug user, it has not gone far enough. There has been some indication that being labelled as ‘sick-but-deviant’ may, in some way, affect a dependent drug user’s behaviour, access to treatment and their ability to recover, but the extent of these affects remain to be disclosed. Further, the effects of the varying different types of stigmatisation, while well known in the mental health field, have yet to be explicitly acknowledged in the field of drug misuse. Finally, and crucially, it is yet to be explained why dependent drug users have difficulties in escaping their negative ‘user’ identity. While many studies have referred to how drug users make attempts to manage a ‘spoiled identity’ or try to restore for themselves a non-addict identity (McIntosh and McKeeganey, 2000; Gibson, et al., 2004; Radcliffe and Stevens, 2008), few explain why their stigmatised identity often threatens to remain their master status. By adopting a Goffman’s broader work on dramaturgy this thesis attempts to address this deficit.

The issues of stigma and its affects will be returned to in Chapter 6 but in the meantime I would like to draw the reader’s attention to another salient feature of this chapter: the emphasis that the ‘sick role’ places on the role of the medical profession as an agent of social control. According to Parsons (1951), it is important for society to maintain social control over people who enter the sick role. Physicians are empowered to determine who may enter this role and when patients are ready to exit it. Because physicians spend many years in training and have specialised knowledge about illness and its treatment, they are certified by society to be ‘gatekeepers’ of the sick role. When patients seek advice of the physician, they enter into the patient – physician relationship, which does not contain equal power for both parties. The patient is required to follow the ‘doctor’s orders’ by adhering to a treatment regime, recovering from the illness, and returning to a normal routine as soon as
possible. The central feature of Parsons (1951) concept of sick role is that the presence of ‘illness’ must be sanctioned by a medical professional. Thus medicine becomes understood as an institution of social control, ‘nudging aside’ the traditional control institutions of law and religion (Zola, 1972). The medical or drug treatment practitioner, therefore, becomes the most appropriate person to deliver action which can control the problems which drugs and their users may cause.

The drug treatment practitioner, however, does not or at least should not work in isolation. Despite drug users consistently described as ‘drug dependent’, ‘addicts’, and ‘problematic drug users’, often interchangeably, they present to treatment with multiple and complex problems relating to mental health, offending behaviour, housing, skill deficits, employment, inadequate or anti-social support networks, and financial needs. Multi-agency and multi-disciplinary working, therefore, have become key features in the treatment of drug misuse. The drug treatment workforce and the criminal justice system, that now have equally significant roles in the treatment of drug dependency, are expected to work together alongside other health-related and social care sectors delivering care and support to socially excluded people to address illicit drug use and the harms caused. Therefore, how and, indeed, why this approach to the treatment of dependent drug users was developed, and the effectiveness of its implementation, will be addressed in the following chapter. As with this chapter and those that came before it, specific attention will be paid to the effects of drug policy and its focus on the regulation and control of ‘risk’, in particular, the PDU.
Chapter 4: Responding to the *problems* of dependent drug users: A review of multi-agency working

“It is by universal misunderstanding that all agree. For if, by ill luck, people understood each other, they would never agree” [Charles Baudelaire, *French poet*, 1821 – 1867]

4.1. Introduction

Much of the emphasis in Chapter 3 was placed on the ‘master status’ of dependent drug users – that is their ‘drug dependency’ or ‘addiction’ and the potential consequences that may ensue from such a label. As referred to in Chapter 1, however, dependent drug users often experience at least one additional significant issue, such as legal problems, inadequate housing, skill deficits, unemployment, inadequate or anti-social support networks, and financial issues, and that these issues are often amplified for those individuals who have co-existing drug misuse and mental health problems (Drake and Wallach, 1989; Johnson, 2000; Frederick, et al. 2003; Neale, 2001; 2008). Furthermore, it has been suggested that these factors often propel these individuals into criminal behaviour as a survival strategy in the community, thereby providing more of a challenge to the services involved in providing treatment (Hartwell, 2004). This chapter, therefore, examines more closely the strategy regarded as necessary to address these problems – that of ‘multi-agency working’.

Over the last 20 years policy-makers in the UK, and abroad, have consistently recommended public sector agencies collaborate in order to address the complex needs of PDUs. Multi-agency working has become a key feature of social policy (Heenan and Birrell, 2006), but as some commentators have argued, “nowhere is it more apparent than in the treatment of drug misuse” (Heath, 2010:185).

Yet, despite these directions it seems that such working practices have remained somewhat fractured and limited (Weaver, Renton, Stimson, and Tyrer, 1999). Dependent drug users
often find it difficult to remain motivated to maintain contact with more than one agency and as a result fall through the net of care (MacDonald et al. 2004).

The aim of this chapter is not only to identify the barriers to multi-agency working but also, through the use of sociological theory, to provide some explanation as to why such barriers might exist within the provision of drug treatment. Before seeking this explanation, however, it seems necessary to explain the shift to a more multi-agency approach within the changing drug policy agenda witnessed in recent years. Focusing on the rise of the PDU concept the first part of this chapter (section 4.2) will attempt to demonstrate why responses to dependent drug use have become centred on the necessity of multi-agency working. This section will also examine some of the barriers encountered in the implementation of this working practice. Then, drawing on theories utilised in the sociology of organisations alongside some of the issues raised in Chapter 2 – the drug worker’s closer alignment with the criminal justice system – section 4.3 seeks to explain why such barriers might exist within the field of drug treatment, thus forming part of the framework within which the data presented in Part II of the thesis will be analysed.

4.2. Responding to the emergence of the ‘new drug user’

It is somewhat difficult to deny the often complex and multi-faceted problems presented by dependent drug users. Chapter 1 demonstrated that dependent drug users often present to treatment services with a combination of problems. Additionally, problematic drug use among women is linked to violence, sexual abuse, exploitation, intimidation and poverty (Drugscope, 2005:21). The associated lifestyle brings many such individuals into situations that are potentially dangerous. This is especially the case for those (predominantly women) involved in prostitution. The result is that the anticipated profile of a dependent drug user is an individual with few social bonds who is socially excluded and potentially vulnerable. Such individuals will also have ‘criminogetic’ needs, which are those needs assessed as being directly linked to offending behaviour and include drug use, poor problem solving, poor decision making, and pro-criminal attitudes and networks.
This level of complexity has been recognised by both the Department of Health and Home Office who have identified the need for more effective joint-working and liaison (Drake and Wallach, 1989; Reed Report, 1993). *Tackling Drugs Together* (HM Government, 1995) reinforced the multi-agency approach to local drug strategy and commissioning through the creation of DATs, comprising representatives from statutory agencies such as health, probation, police and local authorities. Similarly, numerous subsequent policy and guidance documents – the 1998, 2002 and 2008 drug strategies (HM Government, 1998 2002; 2008), *Drug Misuse and Dependence, UK guidelines on clinical management* (DH, 2007), and *Mental Health Policy Implementation Guide* (DH, 2002) – have consistently recommended that health, social care and criminal justice agencies work collaboratively to address the complex needs of dependent drug users. Indeed, the government views the third sector agencies as key players in relation to criminal justice responsibilities, ‘playing a full role in supporting the effective management of offenders’ (Ministry of Justice, 2008:7).

Historically, however, agencies within the National Health Service (NHS) and the voluntary sector have voiced their unease in relation to allying themselves to the criminal justice system (Gibbs, 1999:285; Unell, 2002:229). The implementation of Drug Treatment and Testing Orders (now Drug Rehabilitation Requirements) encountered many difficulties relating to the cultural, ideological and philosophical differences between the treatment and criminal justice staff. Evaluations revealed fundamental problems around interagency working between the two groups (Turnbull, et al. 2000; Hough, et al., 2003; National Audit Office, 2004). The entrenched institutional interests of the health-oriented agencies around care, health and harm reduction clashed with the more coercive, punitive, and abstinence-based ethos of the criminal justice system. There were points of conflict between the requirements of the criminal justice system and drug treatment around issues of confidentiality and information sharing (Barton and Quinn, 2002). The criminal justice system was inflexible in terms of its ability to deal with the complexities of drug use and drug-related offending. Treatment services, on the other hand, had an established tradition of tolerance and support in dealing with poor compliance. Practitioners, therefore, were realistic in terms of defining and redefining ‘success’. For example, for some agencies, the goals of abstinence from drugs and complete cessation of offending behaviour may be too
ambitious. Reduction and changes in drugs use and offending behaviour may be more pragmatic goals. Moreover, the criminal justice system tends to be focused on the short term (the duration of sentence) while treatment services recognise the relapsing nature of problematic drug use and the long term recovery periods needed. Language variations in how individuals were referred to by the different systems and services (‘client’, ‘service user’, ‘patient’, ‘offender’, ‘prisoner’ and so on) also created problems for practitioners working at the interface of these two, what appeared to be, conflicting frameworks. Despite these problems, the coalition between health services and criminal justice agencies is now a strategic imperative. Given such an unlikely marriage it is worth turning back to some of the issues raised in earlier chapters to explore further how such ‘collaborative’ arrangements have come into existence.

It is important to note that the shift towards a more multi-disciplinary approach to the treatment of dependent drug users has not simply unfolded as recognition of the multiple needs of such individuals has developed. Rather, as Seddon (2011) demonstrates, this shift has taken place against a backdrop of wider social change that emerged in the late twentieth century and can be located in the development of the PDU concept.

As a consequence of the changing profile of the heroin user, addiction has become increasingly linked to poverty, deprivation and, importantly, crime. Drug users were once viewed sympathetically and seen as in need of help and treatment – a notion reinforced by the fact that up until the 1960s, drug users were largely middle class, did not generally commit crime to fund their habit and were treated by their own doctors via prescribed morphine and heroin (Berridge, 1999). Addiction was viewed as ‘a personal vice, practiced by those with a mental disorder’, which posed no threat to society as a whole (Unell, 2002:225). Drug users, however, did not remain within the realms of the middle classes and alarm bells began to ring in the 1960s when recreational drug use expanded and was perceived as a threat to young people of any class. By the early 1980s heroin, the main drug of choice, had become a serious problem affecting many large UK cities. It was this change that, according to Seddon (2011), prompted the development and introduction of the term PDU.
As policy makers made attempts to move away from notions of addiction and dependence as a medical phenomenon towards the idea of drug use as a problem, so too did the focus of attention shift to acknowledging the range of problems associated with particular patterns of drug use (and types of drug user). It was then upon this shift that the PDU concept was developed. Introduced initially by the ACMD in 1982 in their Treatment and Rehabilitation report the concept of PDU was intended to make the transition away from the narrow medical model of drug treatment towards a more multi-disciplinary approach:

“The individuals with whom the treatment/rehabilitation system is concerned may have various problems arising from the misuse of drugs or from drug dependency or both. These are not solely physical or psychological problems, but also social and environmental problems, being concurrently psychologically dependent on some drug drugs and physiologically dependent on others, and at the same time having financial or legal problems or difficulties over housing. The response to the needs of drug misuse therefore requires a fully multi-disciplinary approach.

This approach should be problem oriented rather than specifically client or substance labelled. It would be similar to that in the field of alcohol where the term problem drinker has been defined by the Advisory Committee on Alcoholism. Thus, a problem drug taker would be any person who experiences social, psychological, physical or legal problems related to intoxication and/or regular excessive consumption and/or dependence as a consequence of his own use of drugs or other chemical substances (excluding alcohol and tobacco)” (ACMD, 1982:34)

The growing incidence of HIV among intravenous drug users in the mid to late 1980s focused drug policy further towards public health concerns and away from individual-based treatment approaches. Thus, drug-related harm was no longer seen as the sole remit of the person under treatment but society itself was viewed as a source of risk, with drug users viewed not only as transmitters of disease but also as a risk to the public in terms of ‘drug-driven crime’. These concerns are reflected in the then Conservative government’s strategic response to the drug problem, Tackling Drugs Together: A Strategy for England 1995-1998 (HM Government, 1995), which emphasised the need for stronger action to reduce the supply and demand of illegal drugs (Bennett and Holloway, 2005:26). The means of achieving this was to be a strong partnership approach via the introduction of 149 DATs,
which would implement the strategy and adapt it to local circumstances. New Labour continued to build on this partnership approach, launching its strategy, *Tackling Drugs to Build a Better Britain* (HM Government, 1998), the focus of which included major objectives in three areas: crime, young people and public health. Significantly, the role of an anti-drugs coordinator (aka ‘Drug Tzar’) was created whose office was to ‘combine all the resources of the state in the fight against drugs’ (Unell, 2005:233).

The requirement for multi-agency working as a response to the ‘drug problem’ was emphasised further by the introduction of criminal justice led treatment. In an attempt to address ‘drug-driven crime’, Drug Treatment and Testing Orders (DTTOs) were launched as a new community sentence in 2000, being replaced in April 2005 by the Drug Rehabilitation Requirement (DRR). Alongside the introduction of the DRR, the government also launched the Drug Intervention Programme and set up Criminal Justice Integrated Teams (CJITs). The aims of these interventions were to identify and work with non-statutory cases that might benefit from support, advice, assessment and treatment both before and after they come into contact with the criminal justice system. Typically, teams comprise of arrest referral workers based in custody suites, specialist housing advice workers, and outreach and family support workers.

As a consequence of such interventions, agencies that were not previously aligned with the criminal justice system were commissioned specifically to deliver such interventions, thus being forced to embrace a relationship with their criminal justice counterparts in order to ‘direct drug misusing offenders out of crime and into treatment’ (Home Office, 2004: 29).

Despite the consistency of the recommendations to engage in multi-agency working, and recognition that failure to attend to needs in relation to accommodation, employment, training, and education is likely to undermine progress in other areas, multi-agency working has yet to be effectively implemented. Although there has been considerable investment in tackling problematic drug use, little attention has been given to the sequencing of integrated social support (Audit Commission, 2004:3). Baldacchino (2007) suggests that drug misuse and mental health services, for example, are often ill prepared to treat individuals
presenting with drug and mental health problems simultaneously. Hawkings and Gilburt (2004:30) found that staff from separate agencies often hold different views of priorities and there is difficulty in planning joint arrangements, resulting in delayed assessments and reviews. Furthermore, there are clear conflicts between the drug and mental health fields, for example, ‘the medical model of psychiatric services, with their recourse to legal compulsion to treat those incapable of making rational health choices, contrasts sharply with the psychosocial orientation of substance misuse services’ (Weaver, Renton, Stimson, and Tyrer, 1999:137). These difficulties have been amplified through the increasing introduction, over the last decade, of criminal justice agencies and their punitive mandate into the drug treatment milieu (Matrix Heath Knowledge Group 2008; Heath, 2010). Significantly, the 2010 UK drug strategy, *Reducing demand, restricting supply, building recovery: Supporting people to live a drug free life* (HM Government, 2010:5) appears to acknowledge such failings emphasising that ‘although there has been some progress in tackling drug dependence, an integrated approach to support people to overcome their drug and alcohol dependence has not been the priority’.

“The case for treating social problems in a holistic fashion is overwhelming. People know, low achievement at school, bad housing and so on, are connected” (Payne, 1998:12). Given this basic rationale, it is perhaps unsurprising that much of the literature relating to multi-agency working espouses its benefits, both in specific and broad general terms. Those who are successful at multi-agency working and collaboration report many advantages, including: access to resource; shared risk; efficiency; seamlessness; and learning (Ridgely et al., 1998). However, working across organisational boundaries is perhaps one of the most difficult activities that managers in most types of organisation have to accomplish (Huxham and Vangen, 1996). Many collaborative arrangements which begin with good intentions commonly result in frustration and eventually dissipate (Chisholm, 1989). For example, those involved in collaborations often comment on how difficult it can be, or on the amount of energy needed, to encourage participation of key members in the early stages of a partnership (Huxham and Vangen, 2005). When this happens, not only can the benefits be lost, but also a great deal of resource and effort.
Given the complex arrangements required for the delivery of drug services, it is perhaps unsurprising that multi-agency working within this field is so challenging. The meaning of partnership, for example, is often interpreted differently by those involved in the delivery of services and can confuse issues in relation to responsibility and accountability (Heath, 2010). Terms such as partnership working, joint working, shared care, integrated care pathways, and multi-agency working are used interchangeably within the drugs field. Each of these terms seems to suggest that a variety of agencies should participate in a planned, coordinated process to deliver a broad range of services tailored to meet the needs of the individual. Often, however, the priorities of agencies involved in the delivery of services can be stark in contrast. For example, health-related policy makes reference to the ‘care’ process, which involves personal choice reflecting ‘client needs and experience’ (Effective Interventions Unit, 2003:2), while criminal justice policy unsurprisingly reflects agencies joining forces and ‘exploiting diverse skills and knowledge’ to resolve crime for the benefit of the wider community (Crawford, 1997, cited in Minkes et al, 2005:255).

The intention for the remainder of this chapter is to explore further the various debates that might be regarded as barriers to the effective implementation of multi-agency working in the field of drug misuse. The discussion, however, will not simply identify the barriers to effective multi-agency working; this has been done elsewhere (Heath, 2010; Buchanan, 2010). Rather, through the use of theories of organisations, an attempt will be made to explain why such barriers exist, thus forming part of the framework within which the data presented in Part II of the thesis will be analysed.

4.3. Factors determining the success of multi-agency working

A variety of factors play a part in determining the effectiveness of multi-agency working and collaboration. Most commonly, issues to do with aims, culture, communication, power, trust and complexity tend to get in the way of making real progress (Vangen and Huxham, 2006). The barriers to multi-agency working within the field of drug treatment, however, focus more specifically on the difficulties related to establishing a common set of aims and objectives; a difficulty which has resulted from the complex and highly dynamic structures
and arrangements required for the delivery of drug treatment services. Also significant has been the changing role of the drug worker in recent years (Duke, 2010; Best, et al. 2009) and its closer alignment to the criminal justice system which has led to issues around role ambiguity and role incompatibility, factors which have been said to determine the effectiveness of multi-agency working (Jones, 2009).

4.3.1. Aims and objectives

Many authors have argued that if partners are to work together it is necessary to be clear about the aims of such a venture (Huxham and Vangen, 2005:61). Typically, individuals argue for common (or at least compatible) aims as a starting point in collaboration. However, the variety of organisational and individual agendas that are present in collaborative situations often makes reaching such agreement difficult. For example, organisations may have different reasons for being involved in the collaboration, which may lead to conflicts of interest. Furthermore, for some, collaboration may be seen as paramount to the achievement of a purpose, whereas for others involvement may only be a result of external pressures. Similarly, individuals involved in collaborations may have different expectations, aspirations and understandings of what is to be achieved jointly:

“Most of the problems which ran through the implementation…stemmed from the fundamentally polarised views of the key partners which surfaced repeatedly at each level. The tensions and conflicts which bedevilled implementation are one consequence of this polarisation which, once it was locked into the strategy, had been difficult to shift” (Easen, 1998:6, cited in Atkinson, et al. 2002:8)

Establishing a common set of aims and objectives within the drugs field can be particularly difficult, especially given the types and variation of agencies and services involved in the delivery of drug treatment. Public sector organisations, particularly those involved in healthcare provision, have long been recognised to deviate substantially from Weber’s (1947) ideal type, which is able to exclude personal emotions and interests which might detract from the attainment of the goals of the organisation. This ‘ideal type’ contains: officials who have a clearly defined area of responsibility; a chain of command
and responsibility whereby officials are accountable to their line manager both for the conduct of their own official duties and those of everybody below them; operations which are governed by ‘a consistent system of rules; and the ‘application of these rules to particular cases’; and activities which are governed by the rules, not by personal considerations such as feelings towards colleagues or clients. Healthcare provision, however, involves professional workers who require a high level of autonomy in decision-making because of the specialist, complex and indeterminate nature of their work (Mintzberg, 1979). The requirement for a ‘clearly defined goal’, therefore, is particularly problematic for illicit drug treatment. Chapter 2, for example, showed that those working in illicit drug treatment may have very different goals ranging from abstinence to maintenance, from protecting the individual to protecting society, from preventing the spread of disease to reducing crime. Indeed, the foundations on which drug treatment is commissioned and delivered in the UK is, to some extent, governed by various rules and procedures including: The Misuse of Drugs Act 1971, The Drugs Act 2005, the 2010 drug strategy, and key guidance documents such as Models of Care, and the UK guidelines on clinical management. It has been argued, however, that such documents produce inconsistent and often conflicting guidance (Weston, 2008).

Programmes to engage drug-using offenders into treatment were characteristic of drug treatment policy following the 1998 drug strategy (Stimson, 2000; Hough, 2002). To some, the Drug Intervention Programme (DIP), which aims to coordinate treatment for offenders throughout the criminal justice process using schemes such as test on arrest, Restrictions on Bail (RoB), and the Drug Rehabilitation Requirement (DRR) are essential tools to encourage drug users into treatment (Oerton, et al., 2003; Hellawell, 1995), whereas to others they are overly coercive (Hall, 1997; Hser, et al., 1998) and have resulted in the criminalisation of drug policy (Duke, 2006) and the unfair prioritisation of offenders. Rather than clarifying this issue, however, the policy and guidance documents appear to exacerbate the divide by communicating apparently inconsistent and conflicting guidance.

In 2002 the Home Office emphasised the links between drug use and crime:
“The use of drugs contributes dramatically to the volume of crime as users take cash and possessions from others in a desperate attempt to raise the money to pay dealers” (HM Government, 2002:3).

While the 2008 strategy went a step further by recommending:

“Prioritising access to treatment for those drug-misusing offenders who enter through DIP and those leaving prison” (HM Government, 2008:29).

Conversely, the DH, in the UK guidelines on clinical management, explicitly states that:

“Drug misusers in the criminal justice system should neither receive higher priority for their treatment nor should their legal status deny them access to care equivalent to that available in the community” (DH, 2007:75).

Similarly, while the DH (2007:75) recognises the relationship between drug use and offending by stating that ‘there is considerable overlap between those misusing drugs and those committing crime, especially acquisitive crime and drug dealing’, the tone of their recommendations emphasising that ‘the involvement of the accused is voluntary [and] it is not an alternative to prosecution or due process’ (DH, 2007:76), contrasts with Home Office rhetoric where entering treatment is presented as an alternative to being denied bail:

“A new initiative will come on stream to allow drug-misusing offenders to be given the choice by the courts, of entering treatment where appropriate, or being denied bail” (HM Government, 2002:5).

Whether these statements are intentionally conflicting or merely different representations of largely similar viewpoints, they clearly allow for the development of varying interpretations and consequent courses of action. Members of different organisations and agencies often exhibit differing values and beliefs about the way in which drug treatment should be delivered. Indeed, individuals within partnerships may selectively choose aspects of strategy and guidance to support their own agendas and desires to develop services in certain directions, which may be incompatible with the agendas of other partners and
indeed the partnership (Weston, 2008). The Home Office led drug strategies emphasise the need to reduce drug-related crime, which may attract the attention of those working from the perspective of the Criminal Justice System. The documents produced by the NTA and Department of Health, on the other hand, emphasise the need to treat individuals, which may attract the attention of those working within a health and social welfare framework.

In most group situations it is not possible to satisfy all the individual and group objectives simultaneously. As Anzaldula noted (1987), in her account of inhabiting the borderland, there has to be a trade off. In order to achieve the best combined result each individual has to take a risk and accept a less than optimum outcome. This can only happen in certain conditions: if the participants can agree on a common objective; and if they trust each other (Huxham and Vangen, 2005). These conditions will normally happen if: the individuals are given a chance to communicate about objectives, and if they are allowed to prove that trust is justified by putting it to the test in some other way (Huxham and Vangen, 2005). Unless, therefore, the individuals in a group make specific efforts to agree on common objectives and to prove a level of trust, they will tend to promote their own interests at the expense of the collaboration.

4.3.2. Complexity

A factor which has been said to seriously affect the establishment of a common set of aims and objectives and which is particularly relevant for the providers of drug treatment relates to the complex and highly dynamic structures of collaborations. Commonly, organisations have a multitude of alliances, many of which will involve the same organisations in different ways. For many organisations, therefore, no one individual can be expected to know for sure who the partner organisations are let alone the individuals who work within them (Huxham and Vangen, 2005). To add to this complexity, collaborations also tend to be highly dynamic. Staff turn-over frequently affects the relationship dynamics of multi-agency working so effort put into developing mutual understanding can be wasted (Vangen and Huxham, 2006). Moreover, the complex arrangements involved in the provision of drug treatment, alongside the assortment of guidelines and drug strategies, may lead to the
development of informal practices, which may then result in inconsistencies between workers.

Some authors have discovered that informal practices serve to increase efficiency. In Blau’s (1963) American study of a federal law enforcement agency information and experience were pooled and problem solving facilitated. Knowledge of complex regulations was widened and the various ways in which the law could be interpreted were shared. Considerable time was saved since, rather than searching through a thousand-page manual of regulations and books on court cases, agents simply asked each other about a regulation or a reference. Blau argues that assistance and consultation transformed the federal law agents from a collection of individuals into a cohesive working group. This study provides an example to illustrate Blau’s argument that paradoxically, unofficial practices that are explicitly prohibited by official regulations sometimes further the achievement of organisational objectives (Blau, 1963).

In all organisations, groups of workers form and establish their own norms of work practice. These ‘informal groups’ and the norms they develop are an integral part of the structure of organisations. One interpretation of Weber’s model of bureaucracy argues that the most efficient form of administration involves explicit procedures for the performance of every task. If these procedures are strictly followed, and supervised and coordinated by management, then efficiency will be maximised. However, Blau argues that no system of official rules and supervision can anticipate all the problems that may arise in an organisation. Efficiency can only be maximised by the development of informal work norms by groups of workers.

In general, Blau’s research shows the importance of studying the informal structure of organisations. It supports his dictum that a bureaucracy in operation appears quite different from the abstract portrayal of its formal structure (Blau and Meyer, 1971). The drug treatment system, in particular, is rife with numerous strategy and guidance documents, of which not one takes precedence over another. In the absence of specific instructions about how one should treat a dependent drug user, the use of informal structures and practices are
somewhat inevitable. Therefore, although formal and informal structures and practices can be separated for purposes of analysis, in practice they form a single structure.

Other authors have argued that rules in organisations are often ‘stretched, negotiated, argued, as well as ignored or applied at convenient moments’ (Straus et al, 1964:313). In a study of a psychiatric hospital Straus et al (1964) found that there were so many rules that nobody actually knew them all; the senior administrators rarely tried to apply the rules strictly; the overall aim of the organisation – to return patients to the community in better health – was extremely vague and open to different interpretations. Different groups of staff in the hospital tended to support the use of different types of method to achieve the aim. Some psychiatrists supported the use of drugs and electric shock treatment; others put more faith in talking through patients’ problems with them. Often staff could not even agree about the basic question of whether a patient had been cured and should be released. The nurses generally thought that the patients’ mental state could be judged by their day-to-day behaviour. Psychiatrists were more concerned with evaluating deeper and less obvious personality changes in their patients. In these circumstances there was plenty of room for disagreement about whether the treatment was being successful or unsuccessful, whether it should be continued, changed or discontinued. Finally, it was generally agreed in the hospital that no two patients had identical problems, each was a unique case. The staff therefore believed that it was almost impossible to adhere to strict and formal rules and at the same time provide adequate treatment for all their patients.

Many of the issues evident within the psychiatric hospital may also be applied to the drug treatment system. As with psychiatric treatment, drug treatment is governed by numerous strategy and guidance documents, some of which may not be read by all. The overall aim of drug treatment, as we have already seen, is frequently vague and forever changing. Different groups of staff support the use of different methods of treatment, and it is generally agreed that no two dependent drug users have identical problems; each is a unique case (Buchanan, 2010). Those working within the field of drug treatment, therefore, may well believe that it is almost impossible to adhere to strict rules. However, there is a
risk, as Straus et al showed, that in the absence of adherence to a strict set of formal rules disagreement between members and inconsistencies within the system might develop.

4.3.3. Roles and responsibilities

The final factor to be discussed in this chapter, and for the purposes of this thesis possibly the most important, relates to the need for clarity about the roles of individuals and agencies within the multi-agency working framework. Normington and Kyriacou (1994:12), in their research on exclusion from high schools, suggested that problems relating to multi-agency working were mainly found to stem from ‘the mix of role perceptions and expectations the different agencies have about themselves and each other’.

It is often necessary for individuals working in group situations to have a certain level of respect for each other. However, disagreement, confusion, lack of cohesion, professional jealousy and poor communication often conspire to threaten effective teamwork (Molyneux, 2001). Staff, therefore, need to have respect for others and to have the professional maturity and confidence in their own role and professional identity to share ideas and expertise and work effectively together (Chambers and Philips, 2009). This will only be achieved if professionals value each other’s expertise. As illustrated by Jones (2009), failure to value the expertise of others can result in different teams using their specific knowledge to argue a particular position, which can create imbalance within and between teams so that tensions will arise.

There is a danger that, in establishing close working relationships with other agencies, professional roles and responsibilities become blurred, for example, when drug workers and nurses undertake Probation Service responsibilities and vice versa. This is more likely to happen when agencies combine into a team under one roof or when long term secondments occur (Heath, 2010). The strengths of the partnership approach would suggest that collaboration should bring additional qualities, skills and resources together for the benefit of the service user while also enhancing practitioners’ knowledge and understanding of the focus and approach of other agencies. Health workers can therefore expect to gain
understanding of public protection and offender management and, in turn criminal justice workers (probation, police, and so on) will gain insight into health-related issues. However, as Rumgay (2000:138) suggests, workers in this situation very often lose their professional identity and the reality is that those commissioning the services of other agencies can use their contractual power to organise service delivery to their own benefit and thus diminish the professional autonomy of partners and those working at the operational level.

These types of problems can be observed in the treatment provision for dependent drug users. In the final evaluation report on DTTOs, Turnbull and colleagues emphasised the lack of ‘formal and informal roles and responsibilities in terms of which members of staff deliver different components of the intervention to drug using offenders’ (Turnbull, 2000:53). This problem is also evident in the treatment of dependent drug users also experiencing mental health problems (Baldacchino, 2007). In the US, the mental health system is viewed as treating clients “with severe and chronic mental illnesses” but is not seen as “equipped to address the treatment of concurrent substance abuse disorders” (US Department of Health and Human Services, 2002:v, cited by Flynn and Brown, 2008). Conversely, “the substance abuse treatment system addresses all types of substance abuse disorders at all levels of severity; when necessary, many providers in this system are able to respond to mild to moderate forms of mood, anxiety, and personality disorders” (US Department of Health and Human Services, 2002:v, cited by Flynn and Brown, 2008). Consistent with the latter conclusion, clients with non-severe mental illness are more common in substance misuse services compared with the number of clients with high severity (McGovern et al., 2006). However, Cacciola et al. (2001) suggests that the small number of individuals with severe mental illness found in substance misuse treatment services may be evidence of the reluctance of these services to treat the severely mentally ill. On the other hand, there might be conflict about which agency has the power and influence over the treatment of their clients. For example, power struggles between mental health services and substance misuse services may become apparent, especially relating to which service takes responsibility for an individual’s care. This issue is further exacerbated by the guidance provided on how to treat individuals with concurring dependent drug use and mental health problems (Weston, 2008). *Models of Care Update* (2006) and the *UK
Guidelines on Clinical Management (2007) consistently suggest that drug treatment providers should contribute to interventions for clients with severe mental health problems through the Care Programme Approach (CPA). Both these documents suggest that the drug treatment provider should contribute to the CPA, suggesting a multi-agency approach to the treatment of individuals with co-existing drug misuse and mental health problems. This view appears to be in contrast with the Mental Health Policy Implementation Guide (2002):

“Our key message is that substance misuse is already part of mainstream mental health services and this is the right place for skills and service to be... Individuals with these dual problems deserve high quality, patient focused and integrated care. This should be delivered within mental health services [emphasis in original text]” (DH, 2002:4).

While this apparent contrast may be unintentional, the ambiguity has the potential to exacerbate struggles for the power to shape the dynamics of treatment systems at a local level.

4.3.3.1. Role ambiguities and incompatibilities
This lack of clarity around responsibilities may be explained by the somewhat ambiguous roles that drug workers inhabit. According to organisational role theory an individual may be regarded as sitting in the middle of a group of people, with all of whom he interacts in some way (Goffman, 1959; Goffman, 1962; Kahn, et al. 1964; Katz and Kahn, 1966). This group of people is referred to as his role set. The definition of any individual’s role in any situation will be a combination of the role expectations that the members of the role set have of the individual. These expectations are often occupationally defined, sometimes even legally so. The role definitions of lawyers and doctors, for example, are fairly clearly defined both in legal and cultural terms and the role definitions of an actor or bank manager are also fairly clearly defined in cultural terms. The role of a drug worker, however, is less clear. A drug worker might, for example: be involved in outreach work, encouraging people with illicit drug use problems to engage with support services; provide counselling and rehabilitation, giving therapeutic support and dealing with the causes of illicit drug use; be involved in the criminal justice system, supporting clients arrested for drug-related
offences; provide advice on education and training, supporting clients with reading, writing, maths, IT and job search skills; work as a specialist nurse in an addiction clinic, where duties might include prescribing drug treatment and supervising needle exchange programmes; be involved in advocacy, helping clients to use housing, employment and healthcare services, and speaking up for clients in the criminal justice system. Additional duties of a drug worker might also include making risk assessments, designing training and care programmes, and providing support for clients while they deal with their illicit drug use issues. Indeed, a drug worker is required to work with a number of agencies, and in some cases take on a number of roles which may lead to issues around role ambiguity and role incompatibility, each of which may have some impact on their ability and, indeed, desire to work collaboratively with others.

Role ambiguity results when there is some uncertainty in the minds of either the individual or their role set as to precisely what his or her role is at any given time. If an individual’s conception of their role differs from that of others in the role set there will be a degree of role ambiguity. If it is not clear, through role signs of one sort or another, which role is currently the operational one the other party may not react in the appropriate way. Drug workers are, as identified above, required to work in a number of situations and organisations. Working within a police station doing arrest referral work in itself might cause role ambiguity both in the minds of others working in the police station and the offenders. Such role ambiguity may then impact on their working relationships with other professionals. For example, in an examination of the impact of changing roles on relationships between professionals in inclusive programmes for young children, Lieber et al. (1997: 75) found that ill-defined and poorly understood roles affected teachers’ satisfaction with their role and served to undermine working relationships:

“When a child who was blind was unoccupied and given little assistance in an activity led by the early education staff, the special education teacher commented ‘It is hard to see this happen, and then you try to intervene [by making a suggestion] but it’s like how much do you do? It’s like what is our role, are we mother or boss?’”
A further issue to overcome relates to role incompatibility, which results when the expectations of the members of the role set are well-known but are incompatible with the individual’s role. Perhaps the most difficult form of role incompatibility is that which results from a clash between other people’s expectations of one in one’s role and one’s own self-concept. It is possible, for example, for people to construe their professional role differently in some ways from their work colleagues. They might interpret experiences or events differently, allocate importance and view implications of their actions differently from their colleagues; this, for Hymans (2008), resulted in barriers for multi-agency working practices. Ellis (2000) also noted that if workers cannot construe their colleagues’ constructions then problems between people’s inter-professional relationships will inevitably occur. Within the field of drug treatment, viewpoints of criminal justice staff and that of medical professionals have not always been compatible, with criminal justice staff advocating abstinence based approaches to drug treatment and medical professionals advocating harm reduction approaches (Kothari, Marsden and Strang, 2002).

If roles and responsibilities were more clearly defined, as they are in Weber’s (1947) ‘ideal type’ of bureaucracy, problems, such as role ambiguity and incompatibility, may not exist or at the very least be limited. However, the organisations involved in the delivery of drug treatment reflect more closely those described by Burns and Stalker (1961) as ‘organic’ where areas of responsibility are not clearly defined, rigid hierarchies and specialised divisions of labour do not exist and the individual’s role is to employ his or her skills to further the goals of the organisation. When a problem arises, all those who have knowledge and expertise to contribute to its solution meet and discuss and tasks are generally shaped by the nature of the problem rather than being predefined.

In the absence of clearly defined role boundaries and in an effort to protect agency responsibilities, agencies enforce information sharing and confidentiality protocols to the detriment of multi-agency working (Atkinson et al, 2002). This point is made clearly by Maychell and Bradley (1991:39), who state that:
“Obviously professionals have responsibility for maintaining confidentiality and clients and a right to this. Sometimes, however, workers suspect that information of a non-confidential nature is being withheld as a means of retaining a degree of control/authority. Careful negotiation over what really is, and is not, necessary seems to be important”.

Such power relationships seem to be a significant contributor to mistrust and to the hampering of trust building, a common problem experienced by many involved in multi-agency settings. Many have argued that trust is essential for successful collaboration (Lane and Bachmann, 1998; Cullen, et al., 2000). Yet, Huxham and Vangen (2005) suggest that trust is, in fact, a rare commodity in collaborations. Rather than collaborative actions being underpinned by trust, often they are underpinned by a misuse of power, hostility between members, suspicion and mistrust resulting in ineffective multi-agency working

4.4. Conclusion

Dependent drug users present to treatment with multiple problems, relating not only to their drug misuse but also to mental health, offending behaviour, housing, employment, and education. It follows that effective service provision for these individuals must include various types of intervention which address their range of problems. So-called multi-agency working, therefore, has become a key feature of British drug policy. This chapter has illustrated how, in recent decades, policy-makers in the UK have consistently recommended public sector agencies collaborate in order to address the complex needs of PDUs. This increasingly standardised response to the multi-faceted nature of problematic drug use comes despite recognition in wider academic fields that multi-agency working is fraught with difficulties and should, at the very least, be approached with caution (Huxham and Vangen, 2005:13).

Factors determining the success of multi-agency working which are particularly applicable to the provision of drug treatment have been identified in this chapter alongside a discussion about how the drug treatment system fails to address them. Rather than agencies agreeing a common set of aims and objectives it is often the case in drug treatment that
agencies and personnel within them, have differing and sometimes conflicting aims and objectives. Moreover, the degree of complexity in the arrangement of services providing treatment for dependent drug users compounds this difficulty and results in a system which is reliant on the establishment of informal relationships which can often be precarious and subject to change. Importantly, the roles of the relevant agencies involved in the treatment of dependent drug users are also ambiguous, especially given the changes that have taken place in recent years regarding the way they have become embedded within the criminal justice system, having implications for the development of trusting relationships and consequently effective multi-agency working.

A key theme running through each of these factors is that of communication. Some have argued that communication should be placed at the heart of an organisation. Barnard (1938:91), for example, states “in an exhaustive theory of organisation, communication would occupy a central place, because the structure, extensiveness, and scope of the organisation are almost entirely determined by communication techniques”. Indeed, communication is crucial in the treatment of dependent drug use. Providers of drug treatment spend an overwhelming proportion of their time in communications. These communications usually involve face-to-face interactions with peers, superiors, and clients. In short, the business of drug treatment is communication.

The communication process is, however, by definition a relational one. The relational aspect of communication obviously affects the process. The social relations occurring in the communication process involve the sender and the receiver and their reciprocal effects on each other as they are communicating. If a sender is intimidated by a receiver during the process of sending a message, the message itself and interpretation of it will be affected. Status differences, different perceptual models, and so on can also enter the picture leading to distortions of what is being sent and received.

Ignorance of the potentiality for such distortions has been responsible for the failure of many organisational attempts to improve operations simply by utilising more communications (Hall, 2001). Once the importance of communications was recognised,
many organisations jumped on a ‘communications bandwagon’, believing that if sufficient communications were available to all members of the organisation, everyone would know and understand what was going on and most organisational problems would disappear (Katz and Kahn, 1966:430). As we have seen in this chapter, this communications bandwagon is at the heart of the response to the gap in service provision for dependent drug users. Both the Department of Health and Home Office have suggested the need for more effective joint working practices and liaison (Drake and Wallach 1989; Reed Report 1993). Similarly, The Task Force Review (1996) recommended that extensive liaison between mental health, drug services and the criminal justice system needed to be established. Since these recommendations have been made, integration of service provision, including multi-agency working has become a key policy focus.

Unfortunately the mechanics of organisations, and particularly those involved in the treatment of dependent drug users, are not so simplistic that mere reliance on more and better communications can bring about major, positive changes. Rather, one must go beyond the recommendation of more and better communications by examining further the potential explanations for the lack of multi-agency working. Using the theoretical framework set up in this chapter focusing on the informal practices of personnel working within the field of drug treatment and their narratives this examination will be detailed in Part II of this thesis. Specific attention will be paid to the factors identified as relevant here, such as the development of aims and objectives, the importance of role and the existence of complexity. From the theoretical framework examined in this chapter I will attempt to be eclectic, to pick from each anything that helps to understand the workings of the agencies involved in the treatment of dependent drug users and how such explanations can help to identify the issues or factors that might determine access to drug treatment, other healthcare and social services necessary to meet the multiple and complex problems presented by dependent drug users.

Drawing on existing literature and utilising theories from the sociology of health, deviance and organisations, Part I of this thesis has attempted the difficult but vital task of organising the conceptual framework within which the empirical data presented in Part II will be
analysed. Not only have I attempted to explain and theorise the development of drug policy but also considered it as a framework to explain the identity of the drug user and the provision of drug treatment. It has been shown that while drug policy may appear to have changed quite dramatically over the course of the previous 150 years these changes have occurred under the broad umbrella of policy that has adopted a framework of risk-based strategies to regulate and control drugs and its users. Such directions, this thesis has claimed so far, have the potential to exacerbate the problems associated with the identity of the drug user and the way in which their multiple and complex problems might be responded to. After describing the process of data collection Part II of this thesis realises this abstract process through the analysis of empirical data and demonstrates how a ‘risk-based’ approach to drug policy and treatment, which labels dependent drug users as ‘sick-but-deviant’ and views them as a source of ‘risk’, can help to explain the treatment journeys they then pursue. In order to do so, Part II must therefore accomplish the following:

a) Identify the terminology used to describe, understand and treat dependent drug users and to reflect upon how this affects their journey through treatment.

b) Identify the effects of the more recent definitions of, and emphasis that has been placed upon, the term ‘PDU’ on the everyday practices of the drug worker and to identify how these practices implicate an individual’s access to services.

c) Provide an explanation for what seems to be the continued neglect of the various treatment needs presented by dependent drug users and to offer some recommendations for drug policy makers and commissioners.
Part II
**Chapter 5: Methodology**

‘The only means of strengthening one’s intellect is to make up one’s mind about nothing, to let the, mind be a thoroughfare for all thoughts’ [John Keats, English poet, 1795 – 1821]

5.1. **Introduction**

The research presented in this thesis is based on semi-structured interviews with 16 dependent drug users, their key workers and other professionals involved in the treatment of drug dependency, selected from two DAT areas. This chapter, therefore, seeks to describe and reflect upon the methodology that was developed and implemented for the purposes of this research. Presented initially are the research aims and a description of the overall strategy used to meet the objectives. Justification is provided for the methods chosen to research this phenomenon, thereby ensuring transparency and robustness. The process of selecting and accessing the two DAT areas is discussed alongside a discussion about the selection and recruitment of research participants. Finally, this chapter refers to the ethical difficulties that have been overcome in ensuring that the research was conducted in a professional and overt manner.

5.2. **The aims of the study**

Part I of this thesis has placed emphasis on the dramatic ‘transformations that appear to have taken place in British drug policy in recent times’ (Seddon, Ralphs, and Williams, 2008:818). It has demonstrated that while there has been an attempt to explain such policy developments, very little attention has been paid to the practical implementation and operation of current drug policies, particularly with regards to the treatment journeys of dependent drug users and ultimately their chances of recovery. This thesis attempts to address this deficit. Not only does it theorise and investigate the treatment journeys of
dependent drug users, but by situating these journeys within the framework and direction of current drug policies it identifies and explains some of the key issues or factors that may determine access to drug treatment, other healthcare and social services necessary to meet the multiple and complex problems presented by dependent drug users.

While the multiple and complex needs of dependent drug users have long been recognised it appears that their needs, qua their complexity, are still being neglected (Buchanan, 2010; Revolving Doors, 2010). Therefore, the principal aims of this thesis are to provide an explanation for what seems to be the continued neglect of the various bio–psycho-social needs presented by dependent drug users and to offer some recommendations for drug policy makers and commissioners. Firstly, by drawing on the theoretical framework set up in Chapter 3, this thesis will consider the impact of the terminology used to describe, understand and treat dependent drug users and to reflect upon how this may affect their journey through treatment. Secondly, by drawing on the theoretical framework set up in Chapter 4, this thesis will seek to provide an explanation for the barriers to multi-agency working within the context of drug treatment; an explanation which goes above and beyond it being about lack of knowledge, communication, and understanding among professionals and within society.

The aims of the study are:

a) To provide an explanation for the treatment journeys of dependent drug users within the framework of current drug policies.

b) Identify and explain some of the issues which determine access to drug treatment, other healthcare and social services necessary to meet the multiple and complex problems presented by dependent drug users.

c) To develop recommendations for drug policy and treatment approaches that can sustain recovery from drug dependency.
In order to achieve these aims, and after describing and reflecting upon the methodological approach adopted, Part II must accomplish the following:

a) Identify the terminology used to describe, understand and treat dependent drug users and to reflect upon how this affects their journey through treatment.

b) Identify the effects of the more recent definitions of, and emphasis that has been placed upon, the term ‘PDU’ on the everyday practices of the drug worker and to identify how these practices implicate an individual’s access to services.

c) Provide an explanation for what seems to be the continued neglect of the various treatment needs presented by dependent drug users and to offer some recommendations for drug policy makers and commissioners.

5.3. Methodological approach

5.3.1. Research design and approach

The research adopted a multiple case study approach. Two geographic areas, as defined by the boundaries of DATs, were chosen for a depth study. Each DAT (the ‘case’ under study) was investigated by focusing on those services providing treatment for drug dependent drug users. As part of the case study approach the study adopted an in-depth longitudinal follow-up design of 16 dependent drug users and their key workers, across two selected DAT areas.

It was felt that a longitudinal follow-up design would allow for a depth understanding of the treatment journeys undertaken by dependent drug users and the various factors that impacted on them. During a treatment journey, events occur at different times, in different places and involving a mix of professionals and other stakeholders, and these factors may play a part in the different routes that individuals will take. It was thought that breaking down this process and identifying factors that impact on the different routes may help guide the development of treatment approaches that can sustain recovery and/or facilitate movement down one pathway over another (e.g. transition from negative points in the
cycle, such as dropping out of treatment, to positive ones, such as successfully completing or referred on to another form of appropriate treatment).

For example, in order to understand the cycle of treatment, recovery and relapse, Hser and colleagues (1997) argued that a longitudinal dynamic approach is needed to identify key factors influencing drug use and its treatment over time. Examining treatment over time, contrasts sharply with the usual research focus on single-treatment episodes. Drug misusing individuals require more than one episode of treatment to create more substantial changes over time. However, dependent drug users can be difficult to retain in treatment for long periods of time, individuals may only ever receive short term interventions, necessarily limiting the range of services that can be made available to address their multiple problems. Thus, examining treatment on a single episode basis is often insufficient when attempting to illustrate lasting improvements in clients with long-term involvement in drug use and related criminal activities. The treatment journey perspective offers a more accurate picture of treatment received and describes failed treatment episodes as part of the cyclic process of recovery rather than as failed efforts. Hence, a treatment journey perspective provides a framework within which to review the wide range of factors that influence treatment entry, processes, and outcomes. These key factors are of particular interest as they may have important implications for treatment improvement and policy decisions.

A treatment journey approach may help to identify a range of social forces that provide pressure or support for drug use and treatment utilisation. These range from family, peer, and community influences, policy activities and treatment availability. Individual user circumstances may determine only one aspect of how treatment comes to be accessed and utilised. System issues, on the other hand, such as service adequacy, are equally if not more important in the emergence and development of treatment journeys. In this regard, a number of points need consideration.

Historically, the development of drug treatment has been determined by public anxiety and political ideology rather than by research evidence (Tyrer 1998), has been reactive rather
than proactive, and has been uncoordinated rather than integrated (Edeh 2002; Jones 2000; Jones 2001; Rees et al. 2004). However, during the last 15 years, drug treatment has been affected by many changes, including increased funding, and the emergence of Models of Care (National Treatment Agency and Department of Health 2002) and the DIP (Home Office 2003). Although these changes have been politically led, they have adopted an integrated approach. The impacts of these changes and the subsequent effects on treatment journeys may be substantial, and applying a treatment journey approach to a study of drug problems and related needs will enable a comprehensive view that will identify the important effects and interactions of individual circumstances and system issues. This became a key focus to this study and it was expected that such an approach would help policymakers, commissioners, and practitioners in devising more effective treatment that can be delivered more efficiently.

Understanding treatment journeys is inherently difficult, due to the complex detail involved in collating information about social circumstances, drug use, criminal activity, and treatment participation. Ideally, this information would be collated and maintained over a long period of time on a large representative sample of the population. However, researchers have historically relied on retrospective self-reports from individuals (Grella et al. 1999; Grella and Joshi 1999; Hser et al. 1999a) and official records (Gossop et al. 2005). These information sources clearly have flaws: self-report data may suffer from non-response, distortion, and recall error; and official records can be biased because of incompleteness, variations in record keeping, and the differential processes that generate official records. Nonetheless, lacking the information collected from a longitudinal study, these are the best sources available, and they have been demonstrated to be generally valid and reliable in the conduct of research when appropriately used (Gossop, Trakada, Stewart, and Witton 2005; Grella, Hser, Joshi, and Anglin 1999; Grella and Joshi 1999; Hser et al. 1999b).
5.3.2. Methods

A phased approach was adopted for the collection of data, an approach that is commonly used when using grounded theory (Glaser and Straus, 1967). Data collection and analysis occurred simultaneously once fieldwork had commenced so that analysis fed into the data collection and vice versa. This process – a unique feature of qualitative research – allowed for emerging explanations to be ‘tested’ with further data collection.

Data collection occurred through the use of semi-structured interviews and an analysis of case notes.

5.3.2.1. Interviews

When considering which methods to use for data collection issues relating to flexibility, the difficulties encountered in researching drug dependence, reconstruction of events, intrusion, and breadth of coverage were relevant.

Interviews were chosen for their flexibility. Certainly, interviewing, the transcription of interviews, and the analysis of transcripts are all very time-consuming. However, these activities are more readily accommodated into a researchers’ personal life; a consideration quite important given that during the fieldwork I had two small children. It was also important to choose a method that allowed for the interviewee to shape and frame the way the interview was conducted and the issues that were discussed. As Leidner (1993:238) comments, it was deemed important for the interview to have a degree of structure, but to also allow ‘room to pursue topics of particular interest’.

Interviews were also chosen for their ability to research topics and subjects that are resistant to other data collection techniques, such as observation. Asking people is often the only viable means of finding out, for example, about previous drug treatment experiences. Quite obviously, it was not feasible to submerge oneself into the life of a dependent drug user without confronting several ethical dilemmas.
This research has been particularly interested in the way in which dependent drug users and key workers construct their experiences. Thus, it was important to be able to ask participants to think back over how a certain series of events unfolded in relation to their current situation.

It was also important to choose a method that would not be intrusive in the lives of dependent drug users or drug workers. Certainly, interviews can be long but the impact on people’s time is far less than having to take observers into account on a regular basis. It was also thought necessary not to impact on the rhythms of work lives so as not to disturb the situation being studied.

Interviews also provide a breadth of coverage that other data collection techniques cannot. In observation, for example, the researcher is invariably constrained in their interactions and observations to a fairly restricted range of people, incidents, and localities. Interviewing, on the other hand, allows for access to a wider variety of people and situations.

In spite of the apparent proliferation of terms describing types of interview in qualitative research, the two main types are the unstructured interview and the semi-structured interview. In the unstructured interview the researcher uses an aide-memoire as a brief set of prompts to deal with a certain range of topics; this might include just a single question that the interviewer asks, to which the interviewee is allowed to answer freely. This type of interview tends to be very similar in character to a conversation (Burgess, 1984). In a semi-structured interview the researcher has a list of questions, often referred to as an interview schedule or topic guide, but the interviewee has a great deal of leeway in how to reply. In this type of interview questions may not follow on exactly in the way outlined on the schedule. Furthermore, questions that are not included in the guide may be asked as the interviewer picks up on things said by interviewees. Often, however, all questions are asked and similar wording will be used from interviewee to interviewee. Importantly, in neither type of interview does the researcher slavishly follow a schedule as is done in quantitative research interviewing.
However, it was also important that certain information was collected. For example, in order to achieve the aims of the research it was necessary to collect information from service users about their present circumstances, their drug using profile, their mental health, their offending behaviour, and previous and present treatment experiences. The need to collect this type of data, therefore, dictated the use of semi-structured interviews.

The success of this type of interviewing is largely dependent on the ability of the researcher to build a rapport with their participant (King and Horrocks, 2010:48). There are various techniques that can be used and were used in this research to establish rapport. The first technique related to the way the project was introduced. I began by describing the project but importantly I reiterated to the participant the value of their opinions and experiences. I also began the interview by asking unthreatening and simple questions that collected descriptive information about the participant such as, their present circumstances in the case of dependent drug users, or their employment background in the case of drug workers (Appendix D and G). The way I presented myself was also of importance. When interviewing dependent drug users and drug workers I wore casual dress and emphasised my student status. These techniques, I felt, helped to contribute to a more trusting and open atmosphere during the interview. Other non-verbal forms of communication were also used throughout the interview, including visual cues of friendliness such as smiling and maintaining good eye contact.

The interviews were carried out using flexible topic guides, and actual questions and wording were modified as appropriate during the interview according to participants’ responses. These topic guides outlined the key themes and sub-topics for exploration. This approach aided responsive and probing questions which ensured that all relevant issues were explored in detail. Interviews were audio-recorded, with the participants’ agreement, for full verbatim transcription. This was essential for detailed analysis, and also meant that I, as the interviewer, could devote full attention to the participant, facilitating in-depth questioning, and helping to establish a high quality interviewer – interviewee relationship (Bryman, 2012).
In total sixteen heroin dependent drug users were sampled as part of the longitudinal study. These were interviewed using a semi-structured interview schedule at varying stages of their treatment, and were followed up again between 6 – 18 months later. These interview schedules can be found in Appendices D and E. Sampling will be considered in further detail below.

The themes generated from the interviews with drug users were used to guide the production of a semi-structured interview schedule for use with key workers within drug treatment, each of whom were identified by users as having made an impact on their treatment journey, whether in a positive or negative way. Where professionals from services and/or agencies were not identified and sufficiently represented (for example, if there were too few representatives from the criminal justice system), a second set of interviews were carried out with those in order to look in more detail at service provision for dependent drug users. These interview schedules can be found in Appendices G and H.

5.3.2.2. **Documentary Analysis**
In an effort to triangulate and check the data collected from interviews an analysis of case notes was carried out. Before interviewing key workers, interview data collected from service users was checked against their case notes to confirm or deny information provided during interviews. While this process was used to validate self-reporting any inconsistencies between the data sources were also taken into account. This strategy is often used by ethnographers (Bryman, 2012). For example, Bloor (1997) reported that he tackled the process of death certification in a Scottish city in two ways: interviewing clinicians with a responsibility for certifying causes of deaths, and asking the same people to complete dummy death certificates based on case summaries he had prepared.

5.3.3. **Sampling**
The robustness of qualitative research is highly dependent on rigorous purposive sampling (Bryman, 2012). Purposive sampling is a non-probability form of sampling. The researcher does not seek to sample research participants on a random basis. The goal of purposive
sampling is to sample cases / participants in a strategic way so that those sampled are relevant to the research questions that are being posed. Furthermore, it is often necessary to sample in order to ensure that there is variety in the resulting sample, so that the sample members differ from each other in terms of key characteristics relevant to the research question.

For this research every effort was taken to ensure that all samples in the study included a range and diversity in all the dimensions likely to affect experiences, behaviour and attitudes. It was likely, for example, that these dimensions would include location and availability of service provision, age, gender, ethnicity, and prior treatment experience. However, the strength of qualitative research is the flexibility that allows emerging understanding to guide subsequent sampling and questioning. This approach was first used by Glaser and Straus (1967), who used the term ‘theoretical sampling’ to describe the normal method of selecting cases in case study designs. According to Glaser and Strauss (1967:45), theoretical sampling

‘is the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyses his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges. The process of data collection is controlled by the emerging theory, whether substantive or formal’.

This definition conveys a crucial characteristic of theoretical sampling – namely, that it is an ongoing process rather than a distinct and single stage, as is the case in probability sampling. In Glaser and Strauss’s view, because of its reliance on statistical rather than theoretical criteria, probability sampling is simply not appropriate for qualitative research:

‘Theoretical sampling is done in order to discover categories and their properties and to suggest the interrelationships into a theory. Statistical sampling is done to obtain accurate evidence on distributions of people among categories to be used in descriptions and verifications’ (Glaser and Strauss, 1967:62).

Therefore, the sample for this study was monitored as the research participants were approached and selected to ensure that there was sufficient diversity and range. This
flexible approach allowed for early learning in the research to inform the identification of unanticipated issues and to also inform sample selection. For example, very early in the study I noticed that nearly all of the participants recruited had substantial previous treatment experience. As a direct consequence and to ensure diversity with respect to this particular dimension I asked service providers to refer clients who had very little prior experiences of treatment.

Since the research adopted a qualitative case study approach, inferences were based on what is referred to by researchers as ‘theoretical generalisation’ rather than the statistical generalisation common to large scale quantitative research designs. With this approach, cases are selected not because they are representative of the population, but because they represent the range of possibilities in order that valid and challenging tests of the theory are generated.

Moreover, sampling continued until ‘theoretical saturation’ had been achieved. In other words, sampling continued until:

‘(a) no new or relevant data seem to be emerging regarding a category, (b) the category is well developed in terms of its properties and dimensions demonstrating variation, and (c) the relationships among categories are well established and validated’ (Strauss and Corbin, 1998: 212)

For this study, there were two levels of sampling: of study sites and then of participants; a common strategy in qualitative research (Butler and Robson, 2001; Savage et al. 2005).

5.3.3.1. Selection of study sites
The fieldwork for this research was conducted at intervals between 2008 and 2010. The study was carried out in the North West of England and consisted of two cases (or study sites), which were DAT areas. DATs were chosen with care in order to maximise their diversity in terms of a number of key characteristics which may impact upon access to treatment for drug users. In selecting DATs the aim was to achieve diversity in: degrees of
urbanity, as issues for drug-users from less urban areas might be very different from those in large urban cities; and range of services that are available to drug-users.

Once DAT areas were selected, a site scoping exercise was carried out within these areas to identify the following issues:
- the nature and scale of drug use in the area,
- local service provision (including gaps in services), and
- any local issues which may have impacted on the delivery treatment for drug users

This approach firstly enabled an understanding of how the delivery of treatment services for drug users was organised in each area and of the different types of staff involved. In this sense, the scoping exercise provided a good opportunity to check that the DATs selected differed sufficiently in terms of the selection criteria laid out above. Secondly, highlighted issues that may impact on access to particular services in the area informed the design of research instruments used in the study. And finally, this approach was useful in encouraging staff to engage with the study from an early stage, which helped to ease access, and also flagged up possible areas of difficulty.

The location of the fieldwork

The fieldwork was carried out in two DATs. These DATs will be known as West Town and East Town. To allow for easy comparison table 5.1 below summarises the basic data of both towns:

<table>
<thead>
<tr>
<th>Table 5.1 Basic data for West Town and East Town</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population Size</td>
</tr>
<tr>
<td>Number of which are BME</td>
</tr>
<tr>
<td>Estimated number of opiate users</td>
</tr>
</tbody>
</table>

For both West Town and East Town access to drug treatment could be made via GPs, self-referral, interventions in the Criminal Justice System and from other services such as Needle Exchange. As part of the overall system, both DATs commission services to assist clients with housing needs, employability issues, general healthcare, benefits and financial advice, family support and a range of structured day care activities.

Differences in the provision of drug treatment between the two areas, however, were noted. Clinical treatment comprising substitute prescribing – commonly, but not solely methadone – is the standard approach to stabilising opiate (heroin) users. In West Town, this type of treatment was provided through an NHS agency either in various specialist drug treatment centres across the town or in conjunction with GPs through Shared Care arrangements. The NHS agency operates from several specialist sites across the City – one of which is a dedicated service for people with stimulant problems and one which works solely with Probation clients and Prolific and Priority Offenders (PPOs). In East Town clinical treatment comprising substitute prescribing is provided through an NHS agency either in one specialist drug treatment centre or in conjunction with GPs through Shared Care arrangements. Also located within East Town is a service dedicated to offending drug users. This is provided for by an NHS agency alongside input from the police and probation services.

In addition to their standard services West Town also has a service that aims to deliver an integrated package of care to mentally disordered offenders who have needs relating to drugs and alcohol. The service is for people residing in West Town who are experiencing mental disorder or illness and have a history of offending behaviour.

5.3.3.2. Selection of Participants – Research with Service Users

Sixteen individuals across 2 DAT areas were interviewed. Table 5.2 contains the number and breakdown of interviews in each site. Ten were recruited from tier three treatment services and 6 were recruited from service user forums. Of those interviewed, 10 were interviewed again between 6 and 18 months after their initial interview.
Table 5.2  Service user interviews in each site

<table>
<thead>
<tr>
<th></th>
<th>West Town</th>
<th>East Town</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of baseline interviews</td>
<td>7</td>
<td>9</td>
<td>16</td>
</tr>
<tr>
<td>Number of follow-up interviews</td>
<td>3</td>
<td>7</td>
<td>10</td>
</tr>
</tbody>
</table>

**Recruitment**

Prior to undertaking the thesis and in the course of previous research work, connections had been established with several drug treatment agency staff. Not only was this network of informal relationships vital in setting the scene for the research but it also facilitated access to service users. Upon gaining ethical approval from National Research Ethics Service (NRES) and local Mental Health Trusts (MHTs), meetings were arranged with a number of drug treatment service managers to introduce the research and to ask for help with the recruitment of service users.

As part of the participant selection process the following factors were taken into consideration:

**Age:**

Users of different ages are likely to have had different levels of contact with treatment services. It would be expected that some older users (although not all) might have had contact with more services, and more often, than younger, less experienced users. In addition, it is likely that drug users of different ages may be at different stages in their drug using career and their reasons for entering treatment may also differ. This may impact on the routes through treatment that an individual may take. For both these reasons the research selected participants that covered a range of ages within the service user profile.

**Gender:**

The experiences and needs of male service users may differ from those of females, especially in relation to their reasons for entering and remaining in treatment. This study,
therefore, ensured adequate coverage of both groups to be able to explore any variation between them in terms of the factors that have impacted on their routes through treatment.

**Ethnicity:**
The study made some attempt to recruit people from different ethnic minority groups as it is known that drug use differs by ethnic group, as does access to and satisfaction with services. However, it is also known that ethnic minorities are underrepresented in drug treatment services. Khundakar et al (2006), for example, reported that the vast majority (96%) of North West residents in contact with structured drug treatment services in the North West in 2005/06 were recorded as White British. Regionally, no other ethnic group accounted for more than one percent of those in contact with treatment services.

**Prior treatment experience:**
Although some diversity may be achieved by recruiting service users of different ages, gender, and ethnicity it was also considered important to ensure that users who had more and less prior treatment experience were included. Their attitudes to their current treatment experiences, for example, might be impacted by their prior experience of treatment services.

The final sample consisted of 16 individuals, a breakdown of which is provided in table 5.3:
Table 5.3 Service user participant demographics

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Age 30+</td>
<td>6</td>
<td>75</td>
<td>6</td>
</tr>
<tr>
<td>White</td>
<td>8</td>
<td>100</td>
<td>6</td>
</tr>
<tr>
<td>Single</td>
<td>5</td>
<td>63</td>
<td>2</td>
</tr>
<tr>
<td>Unemployed</td>
<td>7</td>
<td>88</td>
<td>8</td>
</tr>
<tr>
<td>Accommodation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rented</td>
<td>4</td>
<td>50</td>
<td>6</td>
</tr>
<tr>
<td>NFA</td>
<td>1</td>
<td>13</td>
<td>2</td>
</tr>
<tr>
<td>Supported housing</td>
<td>3</td>
<td>38</td>
<td></td>
</tr>
<tr>
<td>Left school &lt;=16 years</td>
<td>6</td>
<td>75</td>
<td>8</td>
</tr>
</tbody>
</table>

Further detail about the profiles of the service users are provided in Appendix I.

The UK and European literature on ‘problem drug use’ suggests that most drug users are male and that this type of drug use is most prevalent among individuals in their 20s and 30s (March et al., 2006, Payne-James et al., 2005, Puigdollers et al., 2004). However, in an effort to ensure that women’s views were being heard this study purposely recruited an equal number of men and women. The participants of this study were also older than those in the literature, being in their 30s and 40s. This probably reflects life course issues with individuals accessing treatment following a history of drug use. Many of the participants, for example, talked about escalating drug use and the transition from cannabis, alcohol and solvents to the use of heroin and crack cocaine, as a gradual process and also described how they had entered treatment after using for a number of years.

Although the participants had a wide range of life experiences and came from a range of backgrounds, they did share a number of other characteristics that are similar to those described in the literature. None of the sample discussed owning his or her own home, and some were homeless or had been homeless in the past. Problems with housing and homelessness are common in studies of drug-using populations, with one Scottish study,
for example, finding that over a third of heroin users were homeless at one or both interview points over an eight-month period (Kemp et al., 2006). Similarly, the participants of this study had poor educational attainment, with most leaving school at or before the age of 16. Low education levels have been found in surveys of drug users in the UK and overseas (Puigdollers et al., 2004; Luck et al., 2004).

Physical and mental health problems affect a significant proportion of dependent drug users. The literature identifies a number of concurrent physical health problems, particularly among long-term drug users (Hser et al., 2004). These problems can include higher rates of hepatitis C, HIV/AIDS and physical impairments that can affect a dependent drug user’s ability to complete everyday tasks and therefore, to work (Neale, 2001; Kemp and Neale, 2005; March et al., 2006; Payne-James et al., 2005). The dependent drug users interviewed in this study described their own health issues, primarily linked to their drug use, and reported problems with deep vein thrombosis (DVT) and hepatitis C.

The prevalence of a range of mental health problems amongst dependent drug users is well documented and this thesis has already summarised findings from a number of UK and international studies on this issue. Interestingly, all of the participants interviewed for this study reported some type of mental health problem ranging from non-severe mental health problems such as depression and anxiety to severe and enduring mental health problems such as schizophrenia.

5.3.3.3. Selection of Participants – Research with Service Providers

In addition to research with service users, semi-structured interviews were also carried out with a sample of service providers across each of the two DATs. It was intended that these interviews would provide an additional insight as to how these agencies understand the needs of drug users and their role in relation to them, and how their decisions or actions may facilitate or potentially block access and progression through treatment for these individuals.
In total 18 service providers and professionals within the field of drug treatment were interviewed. Included in the sample were 10 drug treatment workers, all from tier three prescribing services, and one probation officer who had been identified by the sample of service users as having had an impact on their treatment journey. The drug treatment workers interviewed came from a wide range of training backgrounds. Half were trained initially as nurses, of which two had previously specialised in mental health. The remaining half had professional backgrounds in either social work or probation.

The remaining seven professionals consisted of representatives from various agencies involved in the treatment of dependent drug users; these included two DAT personnel, a National Treatment Agency representative, a police sergeant, a dual diagnosis nurse, a housing officer, and a drug treatment service manager.

Further detail about the profiles of the service providers are provided in Appendix J.

5.3.4. Implementation of the research

Having previously worked as a researcher at the National Drug Evidence Centre, University of Manchester, and NDTMS liaison officer for the North West I had privileged access to the field I wanted to research. I had well established links with the North West NTA and local drug action teams, and had developed good relationships with drug service managers and practitioners. Despite such access, however, recruitment of drug users for the study posed a number of problems. This section, therefore, provides a more detailed outline of the recruitment and interview process, the problems encountered, and the potential impacts upon the research presented in this thesis.

Before beginning the recruitment of participants I arranged meetings with DAT managers to explain the purpose and scope of the research. This meeting also gave me the opportunity to conduct a site scoping exercise by asking questions about service provision within the area.
Following this initial meeting, and agreement from the DAT for me to conduct the research, I set up individual meetings with drug treatment service managers where, again, the purpose and scope of the research was explained and agreement for me to carry out the research was sought. These meetings were also used to discuss the practicalities of carrying out the research in terms of recruitment and interview venues. It was agreed at this meeting that drug workers would identify suitable and appropriate individuals to take part in the research and distribute information leaflets accordingly. If agreement was sought from potential participants I then made myself available at their next appointment time within the service.

This recruitment process, however, generated only two participants in as many months. A different approach, therefore, was required. Upon agreement from service managers I spent two days a week in services. This presence not only reminded drug workers about the existence of my research but, importantly, reminded them to approach all drug users who were dependent on heroin and/or crack cocaine. It was then through this recruitment process that the remainder of the service user sample was recruited. Only one of the clients approached refused to participate, but his refusal was a consequence of having another appointment rather than being entirely unwilling to take part in the study.

Once recruited to the sample the participants were asked if they would be willing to be interviewed again six months later. Upon this agreement participants were required to telephone and mail contact information for themselves and at least one other locator. A copy of this contact sheet can be found in Appendix C.

While all the participants agreed to this at their initial interview, as noted previously, only 10 of the original 16 were interviewed a second time indicating a 63 per cent follow-up rate. This attrition was mainly due to those participants moving away, making changes to their contact details, and/or losing contact with the service provider, making them difficult to locate. The drug using population is, after all, a somewhat transient population whose lives are often characterised by chaos (Lowinson, et al., 1997). Tracking drug users for longitudinal research, therefore, can be tremendously difficult (Hanston, et al., 2000). What
must be addressed, however, is the potential impact of such attrition on the analysis of the data presented in this thesis; this will be done in the following discussion.

A major concern of many researchers is that attrition of participants at follow-up may lead to a systematic bias in results. Few would disagree that more participants interviewed at follow-up, the greater the validity of the findings. However, there is no universally accepted rule as to what percentage of a total sample must be retained in order for meaningful analysis of the data to occur (Grant, et al., 1997). Some have argued that a 70% rate is sufficient. Others have claimed that “studies reporting 65-80% may be valid and cannot be dismissed purely on methodological grounds” (LaPorte, et al., 1981:118). Still others suggest that “results based on the easiest to track 60% of the baseline sample were similar to those obtained from the sample ultimately captured [90%]” (Hanston, et al., 2000:1414). The follow-up rate achieved in this research of 63 per cent, therefore, falls within these guidelines.

These types of concerns, however, are often expressed by those carrying out quantitative research. Issues relating to bias, validity and the impairment of the ability to provide accurate generalisations are common expressions of concern.

The research presented in this thesis, however, is wholly qualitative and is not concerned with presenting findings that are generalisable to the wider population. Moreover, the research presented in this thesis is mainly relevant to those dependent drug users who remain in maintenance and prescription treatment for many years, and are considered by many to be ‘stuck’ in treatment (Madden, et al., 2008). As it happens it was these types of participants that were relatively easy to follow-up and are therefore represented in the sample ultimately captured. Those who were more difficult to follow-up had either relocated to another area or were simply no longer known to treatment services. It is possible that these participants were still dependent on drugs and in need of treatment and the inclusion of their journeys may have added further depth to the findings presented. Alternatively, had I managed to follow-up all of the participants, the findings presented may be able to say a little more about the process of ‘recovery’. Importantly, however,
following-up all those recruited to the initial sample would not substantially change the arguments presented about those who are considered to be ‘stuck’ in treatment.

In contrast, the recruitment of service providers posed few problems. As noted elsewhere, service providers were identified by the sample of service users as having had an impact on their treatment journey. Contact was made with such individuals where a mutually convenient time was arranged for the interview to take place.

All interviews lasted between 40 to 60 minutes, with the average service user interview lasting 45 minutes, and the average service provider interview lasting 48 minutes.

5.3.5. Analysis

While grounded theory formed the basis of the analytical approach used, the analysis did include a degree of analytical induction. Grounded theory was chosen to enable the continual analysis of data and the continual development of hypotheses. What differentiates grounded theory from other approaches to research is that its approach is emergent: rather than testing a formulated hypothesis grounded theory offers an opportunity to test an ‘emerging explanation’, developed on the basis of the data as the research progresses. It is driven in such a way that the final shape of the theory is likely to provide the best fit to the situation. However, I do have over 10 years of research experience in the drugs field. Inevitably, therefore, I have approached this study with a set of ideas and hypotheses, which have emerged from both my experience and as a result of familiarity with the literature, both of which may help to explain the continual neglect of the needs of dependent drug users. The policy focus to reduce ‘drug-driven offending’, for example, has led me to consider the impact of the public perception of the dependent drug user.

The analysis was developed through the identification of key topics and issues that emerged from my own experience, literature and, predominantly, from the data. Following this, the data collected was ordered within an analytical framework that was both informed by
existing knowledge and grounded in respondents’ own accounts. This allowed for the accounts of different respondents and groups of respondents to be compared.

The analysis of the data is not a separate stage within the research but an integrated and interactive process throughout the research study (Hammersley and Atkinson, 1995). The use of a constant comparative method of data collection, analysis and theory construction has been suggested to the optimum approach (Glaser and Strauss, 1967). However, data collection and data analysis are both time consuming activities, making it difficult to achieve this level of interaction (Hammersley and Atkinson, 1995). Reflexivity was therefore achieved through the writing of analytic notes and memoranda, which in turn influenced the data collection; guiding and focusing the investigation.

On completion and transcription of the interviews, the task was to read through the interview transcripts, becoming familiar with the content, and looking for interesting patterns and concepts that may help make sense of the data. A fieldwork journal, including notes from the analysis of case notes was considered alongside the interviews. Interviews from service users and their individual keyworkers were also considered alongside each other. Through the use of the theoretical framework set up in Part I of this thesis, a number of categories were identified and the data coded systematically. The process of coding was a recurrent one and resulted in the evolution and emergence of further concepts and themes.

On reaching stable concepts the next challenge was to identify those central to the analysis in order to provide meaning. The data was approached with ‘theoretical triangulation’ (Denzin, 1978) whereby a number of theoretical perspectives were considered. It is this approach which has resulted in a multi-disciplinary thesis, which seeks to explain and make sense of treatment for dependent drug users in the North West of England.

5.3.4.1. Interpretation
Throughout the analysis I was conscious of listening very carefully to the stories that were unfolding. When doing qualitative interviews, subjective meanings and sense of self and identity being negotiated are often heard as the stories unfold. The stories being told are
often reconstructions of the person’s experiences, remembered and told at a particular point in their lives, to a particular researcher/audience and for a particular purpose: all of which will have bearing on how the stories are told, which stories are told and how they are presented/interpreted. For example, a number of studies have shown that the way people express their experiences are problematic indicators of what they have done, or will do. It is not difficult to compile reasons to doubt what people say to us in interviews. It is hardly a revelation to note that people sometimes lie or elaborate on the ‘true’ situation to enhance their esteem and to cover up discreditable actions. Social scientists, for example, have long been aware of the deficiencies of self report crime statistics (Fielding and Thomas, 2001). However, this study was not concerned to search for an ‘objective reality’ or ‘truth’. Instead, the study was interested in the way in which drug users’ and workers’ experiences are told and thus interpreted. Therefore, when analysing the data it was considered important to consistently compare responses within interviews to account for and, indeed, explain contradictions made.

5.4. Ethical considerations

Ethical approval for this study was gained from the National Research Ethics Service (NRES), reference 07/Q1407/Q73. Approval from ‘Research and Development’ was also gained from local Mental Health NHS Foundation Trusts.

Carrying out in depth interviews with dependent opiate users raises a number of ethical issues that needed to be addressed, particularly around informed consent, and confidentiality and anonymity.

5.4.1. Informed Written Consent

It was made clear to participants exactly what was expected of them before being asked to participate in the study, what implications their participation may have, and that they can opt out at any stage if they so wish. Informed consent was accomplished by explaining the study to potential participants and answering any queries they may have. It was thought
essential that the study was explained to participants by the interviewer, rather than by staff at drug treatment agencies. This ensured that the potential participant was given sufficient information for them to give properly informed consent. It was also explained to the participant that participation was entirely voluntary and that consent could be withdrawn at any point (including after the interview has taken place but within one month) without having to give a reason.

The study was introduced to potential participants by describing what it was about and who it was for, and by answering any questions respondents may have about how they were selected and how the findings will be used. Participants were given a leaflet explaining the purpose of the study, to confirm that it was bona fide and confidential and to detail the elements of the study. They were assured of confidentiality and that all findings would be reported anonymously and that participants would be individually identifiable only to the researcher.

Once the leaflet was read and understood participants were asked for their written consent to participate in the interview process – copies of these can be found in Appendices A and F. In addition, separate written consent was obtained from service users in order to discuss their individual cases with service providers – a copy of this can be found in Appendix B. This latter consent was obtained at the end of the interview, because only at this point would participants be able to give properly informed consent: at this point, participants would be certain of what information they provided in their interviews, which they would not know if signed consent was obtained before the interview started.

At the end of the interview process participants were given the participant information leaflet, and a copy of the consent form. Although none of the participants took up the opportunity to contact me, the leaflet did include contact details should they have wanted more information or required reassurance that the study was genuine, or wish to withdraw their consent to any part of the interview.
5.4.2. Confidentiality and Anonymity

It is essential to guarantee confidentiality to participants in a study such as this. Participants were assured that their responses were confidential and that no information which could be used to identify them would be made available without their agreement to anyone, apart from in the circumstances outlined below.

5.4.2.1. Confidentiality during the interview

In accordance with the Data Protection Act 1998, should an interviewer become aware of a situation where there is an identifiable risk of harm to someone who cannot speak for themselves (for example, a child or vulnerable adult) they must inform the relevant authorities. Therefore, when gaining consent, the participant was informed of this potential ‘caveat to confidentiality’ on both the information leaflet and the consent form. To summarise, participants were advised that the following circumstances would warrant instigation of the disclosure protocol above:

- If the research witnesses abuse against a child or any other person,
- A clear statement of ongoing serious harm to, or intent to seriously harm a another person,
- A clear statement of suicidal intent,
- A medical emergency, affecting any person (e.g. participant falls unconscious, any person in the household is seriously injured and in need of immediate assistance). In the case of medical emergency, the researcher will call for an ambulance if they were the only person present who was able and willing to do so.

Throughout the interview, participants were informed that they were not obliged to answer any questions they were not comfortable with (this was made clear in the participant information leaflet and pre interview introduction, and during the interview if it appeared that they were uncomfortable or hesitant). However, when using in-depth interviews to discuss personal, sensitive topics, there is potential for this to evoke some distress in the participant, particularly of recalling different periods of their lives. To manage this, at the
end of the interview, the participant was provided with an information sheet containing information on local and national drugs and mental health support services.

In order that respondents’ answers were kept confidential during the interview process, no one else apart from the interviewer was present in the room while the interview was being conducted.

5.2.2.2. **Confidentiality and security of data stored**

To ensure confidentiality and security of data stored, data was kept during the course of the research in a variety of formats to which the following principles applied:

- Interviews were recorded on mini-disc by the researcher, and backed up as MP3 files onto non-networked computers. The mini-discs were sent to a professional service for transcription, and the transcriber signed a pledge of confidentiality before reception of discs.

- Fieldwork notes (including informal interviews) were kept by the researcher in a number of formats: hand written notes, voice recordings to MP3 files (and backed up to a laptop computer), and via the daily transcription of fieldwork notes and analysis. All data held by me was transferred on a weekly basis to university offices, and thus out of my possession.

- Only I had access to this material. With the exceptions implied above, all material was kept at university offices at all time.

- All paper trace was kept in locked cabinets when not in use, the electronic files were kept on zip discs (that when not in use were also in locked cabinets) and in the hardware of a non-networked computer drive kept in a locked office and protected by passwords.

- The anonymisation of the data and use of pseudonyms took place when the material was first transcribed.

- The voice files were destroyed once the transcription process, involving quality control, was complete (Aldridge, et al. 2010)
5.4.3. Paying respondents

Service users who participated in interviews were given a £10 supermarket voucher for their involvement in each stage of the research, although no travelling expenses were reimbursed. The use of financial incentives for participation in research is now widely practiced; however, this tends to induce mixed feelings, amongst both academics and practitioners, when the participants in receipt of such incentives are drug users or those involved in offending behaviour (Seddon, 2005). Concerns include the rewarding of individuals involved in criminal activity as well as the potential of supporting the funding of illicit drug users (Ritter et al, 2003). However, such anxiety is often based on stereotypes regarding the assumed irresponsibility of drug users and their inability to make decisions regarding the use of such incentives (Ritter et al, 2003).

Concerns raised from the ethics committee about the use of incentives were based mainly on issues related to human rights. It was thought that such incentives may be considered to act more as inducement rather than incentives for involvement in research. In human rights terms, if incentives do indeed act as inducements then informed consent may be jeopardised (Grady, 2001). Drug users who may be considered to be a ‘vulnerable’ group by virtue of a dependency or low-income levels was thought to increase the threat to ethical in this area (Seddon, 2005).

It is difficult to assess whether incentives act as inducements as there are no clear guidelines on appropriate levels. High acceptance rates within research may suggest inducement or could simply indicate that the research is interesting or valued by potential respondents. Within my research several participants expressed surprise at receiving payment on completion of the interview and that they would have participated even if they had not been paid suggesting that the payment had little influence their choice to participate.
5.5. Conclusion

The field work produced a lot of high quality data, the strength of which lies in its rich detail. The combination of a range of data collection techniques – interviews with service users and their key workers as well as an analysis of case notes made it possible for the findings to be checked and ‘verified’. The richness of the data also meant that highly detailed accounts of the processes involved in accessing services relating to drug dependence could be deduced.

The methodological approach does have a number of drawbacks and should be kept in mind when reading the remainder of this thesis. Firstly, this research was a relatively small scale, localised study with an opportunistically recruited group of dependent drug users. Owing to the complex nature of drug dependency and its treatment it would have been virtually impossible to examine every possible permutation of the treatment journeys of dependent drug users and the barriers they confront when accessing services they might require. The study focused specifically on drug users attending services for their drug dependency problems. It does not account, therefore, for the views of drug users not attending treatment, or the views of users of other drugs. Moreover, the sample was drawn from only two DAT areas. While every effort was made to select areas that were diverse in terms of their urbanity, only two variants were allowed: an inner city area and a town. Had this been a study with few time restrictions, a rural area would have also been chosen.

Some reflection must also be made of the method of data collection. Much of the data presented in this thesis was generated from interviews with service users and drug treatment practitioners. It is also important to note that one of the key findings to have been generated from this research relates to the stigmatisation of dependent drug users. It cannot be ignored, therefore, that such stigmatisation may have led to the concealment of information offered by the participants, thinking that there is stigma attached to the ‘truth’. It is not unusual, for example, for research participants ‘to lie or elaborate on the ‘true’ situation to enhance their esteem and/or to cover up discreditable actions’ (Fielding and Thomas, 2001:139). The very idea that research participants are concealing the truth is
particularly problematic for positivists as it challenges the validity of the findings. As referred to above, to overcome this concern the responses were consistently compared both between and within participants. It should be emphasised, however, that this study was not about the search of an ‘objective reality’ or ‘truth’. Instead, this study was interested in the way in which experiences are told and thus interpreted. The explanations that have been presented in this thesis, relating to why an individual’s treatment journey may take particular direction, therefore, may be regarded as one explanation of many. Hence, this thesis offers a theory as to why a dependent drug user’s treatment journey takes on a particular direction and why there exists certain barriers along the way; it does not pretend to be an all-encompassing theory or explanation.

While no claims to wider representativeness can be made, the accounts provided by the participants in this study cannot simply be dismissed as unreliable and idiosyncratic. Rather, they provide an insight into the experiences, views and preferences of dependent opiate users and their drug treatment journeys.
Chapter 6: Explaining a stigmatised identity: The failure of the sick role in legitimising deviancy in dependent drug users

"You become a narcotics addict because you do not have strong motivations in any other direction. Junk wins by default." [Burroughs, 1953: xxvii]

6.1. Prologue

Due to the variety of sources used to collect data on the treatment journeys of dependent drug users I did expect to find some inconsistencies, particularly between that reported by dependent drug users and that reported in case notes and by drug workers. However, amongst the most striking findings of this study were not the contradictions found between sources – these were in fact very minimal – but the contradictions found within dependent drug users’ representations of treatment compared to their objective experiences. At their follow-up interviews some of the participants expressed satisfaction about their treatment often making very complimentary statements about their key workers, as Kevin explains:

“It’s pretty good as it goes compared to some of them I’ve had in the past. She’s got time for you, do you know what I mean?” [Kevin, age 42, follow-up]

Similarly, at his follow-up interview, Reece expressed satisfaction with his treatment more generally:

“I wouldn’t say 100% better but I feel that I’m getting better, I’m getting more confident” [Reece, age 30, follow-up, pg 9].

Yet neither Kevin nor Reece appeared to be making any progress. At their first interviews Kevin had expressed a desire to enrol on an IT training course, while Reece was successfully being maintained on a buprenorphine prescription and had not used heroin for several weeks. However, at their second interviews some time later, Kevin had not attended
any training courses, and while Reece was still attending treatment he had relapsed and was using heroin on a regular basis.

Explanations for these apparent contradictions could well be attributed to both Kevin and Reece’s expectations of treatment. Compared with their previous negative experiences Kevin and Reece may well view their current treatment experiences as positive. However, this explanation seems somewhat dissatisfactory as it fails to fully explain why some dependent drug users remain in treatment for many years making very little progress and showing very few signs of recovery despite assessing their treatment as “pretty good”.

One of the central aims of this chapter, therefore, is to resolve this paradox. Utilising Parsons (1951) ‘sick role’ concept this chapter seeks to demonstrate the potential benefits associated with remaining in the ‘sick role’ and satisfied with a level of treatment that appears to be making little progress in resolving drug dependency and additional related problems. However, by drawing on Goffman’s (1959) dramaturgical approach, this chapter will also demonstrate that efforts made by dependent drug users to access the ‘sick role’ and remain within it produce an asymmetry between the ‘expressions they give’ (i.e. the governable aspects of their behaviour such as the things they say which are conscious and intended) and the ‘expressions they give off’ (i.e. the ungovernable aspects of their behaviour which are unintended). It is then argued that this asymmetry not only denies dependent drug users the benefits of the ‘sick role’ but further discredits and reinforces their already stigmatised identity.

### 6.2. Introduction

It has been argued that the implications of policy and treatment which promotes a disease model of addiction may help to destigmatise dependent drug users (Room, 1983). Drug dependence has been described as a chronic and relapsing condition (NTA, 2002) often taking several attempts to achieve stability or abstinence. The World Health Organisation (WHO) concur that dependent drug use is regarded as a chronic disorder, in which controlling or stopping the drug use frequently takes many attempts, and that relapse is
common (WHO, 2009). Furthermore, the American Society of Addiction Medicine (ASAM, 2011) recently released a definition of addiction supporting the medical model, by suggesting that: “...addiction is a chronic brain disorder and not simply a behavioural problem involving too much alcohol, drugs, gambling or sex.” However, an interesting editorial released in the Lancet (2011:742) suggested that “such an approach might in fact stigmatise addiction, lead to fatalism among patients, and prevent governments from addressing the social environments that increase the risk of addiction—eg, poverty”. Therefore, it is the aim of this chapter to provide an explanation as to why increased, rather than decreased, stigmatisation might result from the continued use of the disease model of addiction. Furthermore, it will explore how such a model might prevent services from addressing problems such as mental health, housing, and unemployment.

Despite the apparent problematisation of drug use illustrated in Part I, the disease model of addiction has continued to dominate drug treatment policy. This approach has remained dominant not only because ‘drug addiction’ has been described as a chronic and relapsing condition (NTA, 2002), but because drugs and drug users pose potential problems which require governmental action, and medical practitioners have become the most appropriate people through which this action can be delivered (Seddon, 2011:33). One of the consequences of the disease model of addiction has been the extension of the ‘sick role’ (Parsons, 1951) to dependent drug users. However, by assigning dependent drug users to the ‘sick role’ the assumption made is that users want to get well and, to this end, seek and cooperate with technically competent medical help. It appears that this ‘role’ is acknowledged within the lay discourse of Western societies, as can be seen by the comments made in interviews cited by Herzlich and Pierret (1987:194)

> ‘When one is sick, one obviously tries to get better as soon as possible. Personally, I do everything I can, I try to do my utmost to be cured as quickly as possible...I would be a good patient, come to think of it’.

And another said:
‘it is a moral duty to recover one’s health, the first duty to oneself and everyone else...seeking help from those who can restore one’s health, that is to say, the doctors.’

The sick role therefore indicates that the person who makes the effort to get well will be granted a social status, as Herzlich and Pierret (1987:53) again explain:

‘to be sick in today’s society has ceased to designate a purely biological state and come to define a status, or even a group identity. It is becoming more and more evident that we perceive the reality of illness in these terms, for we tend to identify our neighbour as ‘a diabetic’, almost in the same manner as we identify him as ‘a professor’. To be ‘sick’ henceforth constitutes one of the central categories of social perception’

While the expressions that dependent drug users ‘gave’ in this study demonstrated both a desire to become ‘drug free’ and considerable efforts to seek treatment, an asymmetry was produced by the ‘expressions they gave off’, which suggested a lack of desire to get well, lack of internal motivation to seek treatment, and when in treatment a failure to comply. For example, the desire to get well, as expressed in Herzlich and Pierret’s (1987) study, was not found in the narratives of the dependent drug users interviewed for this research. On the contrary, being labelled as ‘sick’ was potentially more positive than the labels commonly associated with them, such as ‘smackhead’ (Hunt and Derricott, 2001) and ‘thieving junkie scumbag’ (Radcliffe and Stevens, 2008), who may also be stigmatised for their mental health problems, criminal record, lack of employment opportunities and homelessness. The irony is, of course, that through the expressions they give off dependent drug users fail to meet the criteria of the ‘sick role’ laid out by Parsons (1951) resulting in their access to this role regarded as illegitimate, further reinforcing a stigmatised identity rather than transforming it.

One of the main aims of this chapter, therefore, is to begin a dialogue that helps to explain the stigmatisation of dependent drug users; an explanation which goes above and beyond it being about lack of knowledge and understanding among professionals and within society. As demonstrated in Chapter 3, some commentators have suggested that stigmatisation is a consequence of seeing drug addiction as a criminal and/or moral issue (Drucker, 2000), which is perhaps a good starting point but fails to provide an adequate and complete
explanation. Other commentators have focused on the illegality of ‘controlled’ drugs, as Hunt and Derricott (2001:191) explain: “through legislation the state says drug use is a crime and is therefore bad, ipso facto, drug users are bad and rightly stigmatised”. Earlier chapters emphasised how, through changes in drug policy, the increasing alignment between medicine and the criminal justice system, the rise of the PDU (observed in Chapter 2), and the official and media discourse surrounding drug use (observed in Chapter 3), dependent drug users are held responsible for their addiction. Responding to drug dependency in a predominantly medical way, however, does not remove this responsibility. Rather, it assigns a label to dependent drug users that is wholly more positive than their current label of ‘thieving junkie scumbag’ or ‘smack head’; a label which has the potential to legitimate their otherwise deviant behaviour. However, through the ‘expressions they give off’ the drug users of this study appeared to lack the desire to ‘get well’ and failed to seek and cooperate with technically competent medical help. As a consequence of these ungovernable aspects of behaviour, as alluded to in Chapter 3, their access to the ‘sick role’ is regarded as illegitimate, and thus their deviant status remains. The medical approach that is seen in the treatment of drug dependency, therefore, does not reduce the stigma associated with drug dependency but further reinforces it.

This chapter turns back to many of the issues raised initially in Chapter 3. The first part illustrates the various experiences of stigmatisation encountered by dependent drug users. Supporting existing research (UKDPC, 2010; Radcliffe and Stevens, 2008), this chapter initially focuses on the experiences of stigmatisation encountered from external sources such as drug treatment services, GP surgeries, local communities, and potential employers. To add to this insightful body of research, the chapter will then draw attention to the stigmatisation experienced by dependent drug users from internal sources. As suggested by Dunion and McArthur (2011), the negative attributes associated with drug dependence become self-evident ‘truths’, which influence the beliefs and attitudes of dependent drug users resulting in self-stigma. In other words, experiences of stigmatisation from external sources have distorted the perception of dependent drug users in terms of how they think they will be treated by services and their local communities. Moreover, this chapter will show that dependent drug users stigmatise themselves and consequently become withdrawn
and isolated from society having implications for their treatment progression and recovery. The second part of this chapter demonstrates how dependent drug users then make attempts to transform this stigmatised identity, either through the process of maintenance and access to the ‘sick role’, or through the process of abstinence; of which the latter appears to be more successful.

6.3. Stigma of dependent drug users

Many of the study’s drug user participants reported having at some point within their treatment career experienced stigma. Such attitudes manifested themselves not only in the way they were treated and perceived by others but also, and perhaps more importantly, in how they perceived themselves. This section, therefore, is divided into two parts. The first part demonstrates the extent to which dependent drug users experience stigma from external sources, while the second part demonstrates the extent to which dependent drug users experience stigma from internal sources.

6.3.1. Stigma from external sources

Many of the drug user participants described experiences of direct discrimination, particularly from their families, local communities, GPs, housing associations, potential employers and, in some cases, their own drug workers. Reece, a thirty year old male who had been using illicit substances since the age of 11 described how his family rejected him because of his drug use:

"And I’ll start sorting myself out and I’ll have my family round me again, you know, it’s just they’ve all turned on me because they found out I’ve used again. They don’t understand that I’ve had problems, they just see the bad things straight away, like you’ve took drugs again, you know, they don’t understand" [Reece, age 30, follow-up]

Similarly, Jim describes how the use of drugs cost him his family relationships:
“I just lost it all through drugs really. It cost me my family relationships, it’s messed my life up you know, it’s cost me quite dearly” [Jim, age 60]

Others describe, not only how they have been rejected by their families but also how they have been rejected by their local communities, and labelled as ‘smack heads’, as Kevin and Reece explain:

"sometimes I don’t want to go out of the house, I think oh I can’t be arsed with all the kids hassling me and all, you know, you know what teenagers are like nowadays don’t you, especially how I used to look and all, you know what I mean, I were a glutton for punishment so it’s expected I suppose when they throw empty cans at me and call me a smack head and all that but since I got me hair cut and changing my clothes and getting me, er, looking after meself, you know what I mean, I don’t hardly get any grief so I don’t mind going out now" [Kevin, age 40]

"if I went back there [home to girlfriend and son] with all the intentions of being a good man and trying I just know I couldn’t because round there it’s just a little town and all my friends are druggies and all the other people hate me because they think I’m a smack head" [Reece, age 30]

Further experiences of discrimination came from GP surgeries. Wayne, a 39 year old user of illicit drugs described the frustration he felt when accused of stealing a prescription from his GP surgery. Frustration, which cost him access to his GP and his much needed medication for emphysema:

"Well the one that I had before, they don’t like me because I was arrogant with some of the staff, they was arrogant with me so I got my hair off with them, and anyway they sacked me, they accused me of taking a form, they had me arrested for it and then, it wasn’t me who did, I wouldn’t do that, anyway they took me down four times to the bloody police station, and then oh I’m sorry Mr xx it wasn’t you, and then they just kicked me off. I should be on warfarin, I’ve not had my warfarin for god knows how long, I’ve got emphysema..., I should have dihydrocodeine for the pain in my legs, I’m on, I should have inhalers for emphysema, asthma...I’m having to borrow one of my mum’s inhalers" [Wayne age 39]
When Wayne was asked whether he could approach his GP, he replied:

"I haven’t got one, they sacked me so I need to get one. [My worker] said there’s a place taking on but everytime I go to one they just tell me to piss off" [Wayne, age 39]

Susan, a recovering user and member of a user forum, explains how many GPs see users as only wanting access to more drugs:

"If they just listened to what you needed, they see everyone as, oh they’re all on the make, they're all after drugs, they're all this, they’re all that and they don’t treat you as an individual at all. They don’t listen to you at all” [Susan, age 43]

Discrimination from GPs appears to be a shared concern among the drug worker participants also. Beverley, a senior substance misuse practitioner, described the inconsistency between GPs, with some more interested in working with users than others:

"Some GPs are better than others. Some GPs are quite proactive and are on board with you and are quite interested in that client group and then other GPs are totally not interested in that client group and just, the least they see them the better really...I think they just view every client that’s a drug service client, that they’re after some kind of drug" [Beverley, Senior Substance Misuse Practitioner].

In addition to discrimination from GPs, Bill, a substance misuse liaison worker, talks about the discrimination from others in the medical profession:

"Prejudice, in and out of the profession...Against drug using clients, they’re not getting access to treatment, being treated different, whether it be in the GP surgery or whether it be in the hospital.... I always compare the alcohol with the drugs, and there’s less resistance and less fear and less prejudice against alcohol using clients than there is against drug using clients and I think there’s lots of reasons for that, it’s still socially acceptable to get drunk but not socially acceptable to get off your head with heroin. And there seems to be a greater understanding of alcohol related problems in a purely physical way say, than, you know, you hear nurses saying well drug users brought it on themselves, self-induced, you know, so what couldn’t you say that about, I don’t know, obesity, they’re eating too much, you know, rather than it’s from birth, that they’ve eaten too much, that’s self-induced. There’re lots of
self-induced illnesses, cancer of the lung from smoking 40 a day for the last 20 years, self-induced, and yet you’re not prejudiced against them but you are against a drug user. Drinking a lot, nobody actually pours it down their neck, they do that themselves and yet there’s not that, there is some degree but there’s not that acute degree of discrimination" [Bill, Substance Misuse Liaison]

Kelly, a drug worker, described the difficulties she had when trying to transfer Claire, her client, to shared care. Claire was stable, attending appointments and taking her methadone but because she and her partner had decided to travel around the UK in a motorhome, transferring her to shared care became fraught with difficulties:

"I wanted [Claire] her to be transferred to shared care, to move to one of the GP clinics, which I did a few weeks ago and they wouldn’t take her because she said she was going off travelling, which shouldn’t really have made a difference. If I could see her once a fortnight so could they but the GP wouldn’t take the case on, so she’s ended up coming back here, which isn’t good really because she’s quite stable, it’s not good for her to come here and sit in a waiting room full of people that are much more chaotic than she is...and this kind of thing happens quite regularly...GPs are paid specifically to take these clients, they’ve got a specific number of slots in each clinic that we’ve got to fill, so I don’t really know what the issue is...some GPs are more open than others” [Kelly, Senior Substance Misuse Practitioner]

Discrimination from housing providers was also highlighted as a particular challenge. Andy, a senior housing strategy officer, described the fear around housing ex offending drug users:

"I suppose the conflict is that for social housing is to make our housing accessible to those in need of housing with drug misuse backgrounds, and ex offenders, we talk a lot about doing that but the converse of that is from their point of view is to ensure that we have safer communities and there is a lot of fear around housing an ex offender who has a drug habit and some of our [housing providers] can be very conservative about that, from our point of view we have to try to unpick that sometimes” [Andy, Senior Housing Strategy Officer]

Similarly Ann, a drug interventions programme manager, emphasised the difficulties in housing drug using clients:
"Not so great relationships with housing options, I think we tend to feel, they don’t view our clients very positively, there’s a lot of hurdles for them to jump through to even get on the housing register" [Ann, Drug Intervention Programme Manager]

For some individuals, direct experiences of stigma came from their own drug worker. Claire and Adele explained how they felt that their drug workers were often judgemental:

"Once when we were in the one bedroom flat, we’ve got two dogs and she came round, I tidied the flat up but the kitchen was a mess. And she’s very judgemental and she came in and she turned round and she went, sniff, she said it smells of wet dog. And that’s the kind of person...But she were kind of, you know, looking down their nose at you and things like that" [Claire, age 33]

"I think there’s some people who really try and they want to help you but there are these other ones who will just treat, I don’t know, the profession that they’re in I feel like you’ve got to treat it more than just a job, more than just a wage, you’ve got to want to work with people who are on drugs, and not just look down your nose at them, you know, I’ll be alright I’ll be going home in an hour, I won’t have to look at their faces, you know what I mean, I don’t know, that’s how I feel about a lot of them " [Adele, age 35]

Susan described the lack of facilities for fresh water in the reception of her local community drug team, demonstrating for her the attitudes of the service in relation to the behaviour of their drug dependent clients:

"The whole service is crap, it’s really crap this service, they’re not doing anything to make it any better. It’s only the user forum really that’s doing anything to try and improve that service but it takes forever to get anything. I mean just to get a water bottle in reception, obviously it’s took us a year and we’ve been allowed to have one but it’s still sat in the basement, so nobody’s getting any benefit out of it...Because you can use water to inject with can’t you? Do they really prefer you to go and use dirty puddle water? And if they did give you a drink of water in substance misuse team, you had to stand at reception and watch you drink it all. And also, I’ve seen someone in there, walk in there and she was a bit worse for wear for drink and one of the reception staff asked her to walk in a straight line, like a copper would, I mean who’s she qualified to judge whether she’s walking in a straight line
or not? It’s a service for addicts, they’re absolutely appalling some of the people in there"
[Susan, age 43]

According to Luoma et al (2007:1342) stigma related rejection may make it more difficult to succeed in recovery. However, one of the main consequences of stigma-related rejection is the effects it has on an individual’s perception of stigmatising attitudes in society and, perhaps more importantly, their perception of themselves. This unfortunate consequence was acknowledged in the comments made in interviews cited by Dunion and McArthur (2011:34):

“Feeling judged by other people because of their negative attitudes towards people with mental health problems leads to self-stigma. Self-stigma dents your self-esteem and you hold yourself back as a result”.

It is important, therefore, to consider more closely the effects of such stigmatising attitudes in society on the behaviour of the dependent drug users interviewed for this study.

6.3.2. Stigma from internal sources

Many of those interviewed believed that stigmatised attitudes and actions were prevalent in society, and these appeared to impact upon their subsequent behaviour. A fairly strong feature of dependent drug users’ lives was social withdrawal and isolation from both their local community and those people they cared about the most. Reece described how he ended his relationship with his partner to avoid hurting her further:

"I went to jail and I just thought I’d had enough now. I rang my partner and I said look, if you want I’ll understand, if you want to get on with your life because I love her more than anything, she’s my world, I still love her now but I can’t live there and hurt her, I can’t be a person that’s hurting someone that I love so I said, look, it might be better if you just get on with your life and I’ll just leave you to it" [Reece, age 30]
Others expressed having become afraid to leave the house making ‘reintegration’ into society inevitably difficult, as Beverley and Tim describe when talking about their clients Kevin and Stuart:

"Kevin doesn’t like to go out, he’ll lie in bed, he says he wants to do stuff but he just hasn’t got that motivation, he just lacks all enthusiasm for everything" [Beverley, Senior Substance Misuse Practitioner].

"On the last appointment Scott wanted me to come to him, again it’s about not wanting to come out of his home, which I didn’t do, I told him he’s got to get here. And he wanted adjustments made to his prescription, so again he doesn’t have to go out every day" [Tim, Senior Substance Misuse Practitioner]

According to Dunion and McArthur (2011:51) a ‘loss of confidence, growing self-doubt and a worry about how others are going to act can often lead people to change their behaviour’. During interviews a number of examples were uncovered of dependent drug users choosing not to do certain things in fear of the reactions of other people. For some, even going about their daily business, such as shopping, became difficult, as Jon and Cara explain:

"I’m not really getting any better in that respect, I just learn how to avoid it, do you know what I mean, how to avoid the situations but I can’t really function normally in life because I can’t go shopping and things like that. I have to go shopping at daft hours in the morning, when the supermarket’s quiet or I have to go, it always has to be with people I know and I can’t just go and do things that I want to do or go places" [Jon, age 33]

"anxiety, I feel like I get panicky when I go out, some weeks I can’t even go shopping, I have to ask my mum to do it for me, I just have to make an excuse that I feel ill or something and, the depression, I feel as if people will look at me when I go out, just not the same, I don’t wear the clothes I used to wear, I don’t dress up anymore, I don’t go out, you know, it’s not nice" [Cara, age 22]

Not only do such perceptions act as barriers to ‘recovery’ but also as barriers to accessing services they might require. For example, Jon describes how he refused to take up the offer
of help from his drug worker regarding a housing issue for fear of being discriminated against:

"I think it was offered but the stigma attached to it, you don’t want to be going to the housing places from drug treatment because, you know, a lot of them won’t house you, or you think they won’t, and you don’t like to say you’re in treatment" [Jon, age 33].

Similarly, Jamie felt that he needed some help with his mental health but refused to see his GP for fear of being accused of wanting more drugs:

"I feel that that would help but the problem I have, I won’t go and put myself in front of a GP and start saying to them that I feel like I’ve got, because I think that they think that I’m just after a valium script or something and to be honest it’s definitely not the case. I don’t doubt for a minute that they’ll probably help me with my, but I’m not going to ask a GP because they’ll think that that’s all I’m there for, not for the help, just for the fact that I want the script so I won’t bother, I feel like they’ll put me down when I’m sat there in front of them, so I won’t do it" [Jamie, age 29]

Experiences of stigmatisation or fear of being stigmatised may lead drug users to internalise their problems resulting in feelings of self-stigma, often manifesting itself in shame, and negative thoughts and feelings about oneself, as Kevin and Reece explain:

"I just hate being on the social, I hate it, but I don’t know, the more gear you do the more sort of paranoid you get and the less you want to interact with people, it puts you off from going on courses or applying for a job because you think, well I haven’t worked for so long, I’ve got a criminal record, I’m an ex user. Nobody’s going to touch you are they? The only job I’m going to be able to get is basic like run of the mill sweeping up of a warehouse floor something, you know, mopping toilets. Don’t get me wrong, people who do it, you know, like do a good job but I don’t want to be doing something like that. I want to get a wage in my hand, feel proud, I earned that money. I know what that’s like, when I used to work before, you know, you do, you get a buzz of it, grafting your own dollar, do you know what I mean" [Kevin, age 40]

"It was horrible, I used to hate it, I’d look in the mirror and smash it up because you’re just a machine, you know what I mean, it’s just disgusting... and my Mrs didn’t like it ‘cause she
didn’t take drugs, I had my son, I just didn’t like it at all. It made it worse for me with my other [mental health] problems ‘cause I hated myself that much” [Reece, age 30]

Experiences of stigma, whether they are of an external or internal nature, raise a range of negative implications for drug users, affecting their sense of well-being, self-esteem and motivation to seek treatment and ‘get well’. Receiving a continually negative judgement, one that does not separate the whole person from activities in which they engage, cannot aid or drive an individual away from drug use. Rather, the negative label attached to users of illicit drugs may, to some extent, be self-fulfilling as Warburton and colleagues (2005) argue. In other words, the user who accepts or internalises the stereotypical ‘junkie’ identity will then behave in the expected manner, further reinforcing the stigma associated with them.

Furthermore, the negative identity associated with dependent drug users excludes them from other more ordinary, everyday activities and roles, such as becoming a parent or maintaining a full-time job; roles that have been socially constructed as incompatible with the role of dependent drug user. Claire, for example, talks about her desire to become a mother again but explains that she could not possibly become pregnant while still using:

"We’ve been to fertility clinic but because I was on crack and stuff I didn’t want to, I felt as though I’d be abusing the system. When I see these heroin addicts, I mean I know I am, but heroin addicts that are getting pregnant and the kids are getting took off them or they’re coming out addicted, you know, I wouldn’t want to do that" [Claire, age 33]

Not only is the role of dependent drug user incompatible with everyday activities and obligations, but also incompatible with such activities is the role of being ‘sick’. Jill and Jamie both explain the difficulties in having a full-time job, using drugs and being in treatment:

"When I was working I couldn’t always sneak out and use [drugs] because it was twelve hour shifts and that and sometimes we couldn’t get it before I’d go to work at 8 o’clock in the morning so that’s why my job went basically" [Jill, age 27]
"I was working on the roads on my last job and we were laid off, it was just a temporary contract doing the CCTV, and we were laid off and told not to come back until the end of February to see if there's any work then but as I say that's not really practical for me because for starters I have to get my medication every morning, and as I say three days out of five I’m committed to one of these interviews, appointments, you know, so really I’m just holding out until this order finishes before I start worrying about that" [Jamie, age 29]

The stigmatisation experienced by individuals who use illicit drugs has a number of implications for treatment progression and recovery. Research indicates, for example, that psychosocial factors, such as stable accommodation, the development of new and stable relationships and engagement in new activities are critical in the recovery of drug dependence (Vaillant, 1995; Watson and Sher, 1998; Drake, Wallach, Alverson and Mueser, 2002). Yet, in fear of being rejected, some of the participants in this study expressed concerns about asking GPs for help with their mental health problems, and some avoided asking for help with accommodation from housing services. Others became withdrawn and isolated, distancing themselves from loved ones, ending relationships, and unable to partake in routine activities making recovery and reintegration into society inevitably more difficult than it might otherwise be if help with these other challenges was available and forthcoming.

There is little doubt that the underlying strategy concerned with the regulation and control of drugs, designed in part to deter people from using drugs, coupled with the media attention and subsequent policy reaction, has resulted in the widespread discrimination of dependent drug users. Consequently, in addition to overcoming drug dependency, one of the biggest hurdles dependent drug users face is repairing a ‘spoiled identity’ (Goffman, 1963). The remainder of this chapter, therefore, examines more closely how the participants of this study made attempts to transform their stigmatised identity.

6.4. Transforming a stigmatised identity

Consistent in the literature on stigmatisation of drug users is the concept of the drug user’s ‘spoiled identity’ and the necessity to restore for themselves a ‘non-addict’ identity. Many
authors have demonstrated how drug users frequently seek to divorce themselves from a negative drug user identity, a process that has been referred to as ‘distancing’ (McIntosh and McKeeganey, 2000; Gibson, et al., 2004; Radcliffe and Stevens, 2008). This type of ‘management of a stigmatised identity’ was certainly evident in some of the accounts of the participants of this study. Jill, for example, frequently used the tactic of divorcing herself from the negative drug user identity:

"I’ve seen what [heroin] can do to people who’ve been on it for twenty odd years, and I’m not gonna be one of them... I don’t want to keep coming to places like this [drug service], seeing all people that are here, and once it’s done, it’s done" [Jill, age 27]

This chapter, however, is not interested in how dependent drug users manage their stigmatised identity; as Neale and colleagues (2011b:4) quite rightly point out, ‘this approach seems somewhat derogatory as it implies that the stigmatised identity is a more totalising identity from which it can be difficult for individuals to escape’. Instead, this chapter is interested in how dependent drug users make attempts to transform their identities. Upon analysis of the data there emerged two very different, and almost opposing, approaches.

The first approach is explained through the use and application of Parsons (1951) ‘sick role’ concept. While the ‘sick role’ confirms the dependent drug user’s addict status it nevertheless has the potential to legitimise their deviant behaviour. Being ‘sick’ also provides them with a role that is wholly more positive than that of ‘homeless’, ‘jobless’ ‘thieving junkie scumbag’ (Radcliffe and Stevens, 2008). However, by drawing on Goffman’s (1959) dramaturgical analytical approach, it is shown that efforts made by dependent drug users to access the sick role, and remain within it, produces an asymmetry between the ‘expressions they give’ (i.e. the governable aspects of their behaviour) and ‘the expressions they give off’ (i.e. the ungovernable aspects). This asymmetry not only denies dependent drug users the benefits of the ‘sick role’ but discredits and throws doubt upon their projections thus reinforcing their already stigmatised identity.
The second approach described in this chapter was used by two of the participants interviewed. Both had become abstinent from all drugs and both had transformed their stigmatised identity either by joining the drug treatment workforce or by detaching themselves completely from drugs and drug users.

6.4.1. Transformation and non-transformation through ‘sick role’ maintenance

While the ‘sick role’ confirms the dependent drug user’s addict status it nevertheless has the potential to legitimise their otherwise deviant behaviour and exempt them from normal social obligations. For example, in an effort to legitimise his offending Jamie insisted that he only ever offended to fund his drug use:

"I never started committing crime before I started using drugs" [Jamie, age 29]

Yet moments earlier he had reported that the first time he had used drugs was a consequence of being kicked out of his home by his mum for offending, implying of course that his offending started before his drug taking:

"To be honest the first time I ever used I was going through a bit of turmoil with my family, my mum had kicked me out, I had to move into a hostel, my family had stopped speaking to me for a while because I was committing crime and I ended up trying crack one day and trying heroin the same week and as I say for the first three or four years I only ever dabbled, you know, after which such a time I started to use every day and before I knew it I had serious drug habit you know" [Jamie, age 29]

Michelle also insisted that her offending behaviour was due to her addiction:

"I’ve been committing offences, doing a lot of shoplifting to support my drug habit” [Michelle, age 35]

In an effort to explain his offending behaviour, Stuart not only uses his addiction status but also uses his mental health problems:
"Mainly all thefts, shoplifting but that’s where the voices are coming in because, they’re kind of like adolescent voices, you know, like they’re talking me into doing this and that and the other and just to get rid of the voices I’m going out shoplifting to buy the crack to get rid of the voices, you know, and sometimes the voices are telling me to do it, you know, and I’ve only just started talking about this actually to the psychiatrist and probation and that lot, that the voices are actually, that the voices do tell me to do it sometimes" [Stuart, age 38]

For others the status of ‘addict’ or being ‘sick’ exempts them from having to fulfil normal social obligations. Joe, for example uses the status of ‘addict’ to explain why he was unable to reach his full potential academically:

"I mean I don’t want to completely blame the drugs but I think it’s robbed me of my potential really, although I’m young enough to salvage something, I don’t think I’ll ever get to the level that I could have done without drugs, definitely" [Joe, age 29]

Similarly, Jill uses her addiction to explain why she was unable to maintain employment:

"Well I did used to work until I got on drugs, and then I couldn’t hold down a job" [Jill, age 27]

Wayne not only uses his addiction to exempt himself from normal social obligations but also uses other health problems:

"I’m having to borrow off Peter to pay Paul, it’s, you know what I mean, it’s really, really hard. I can’t work, with my legs, I just can’t do it" [Wayne, age 40, follow-up]

Similarly, Kevin uses his hepatitis C diagnosis to explain why he has been unable to uptake educational training programmes:

"Well it [hepatitis C diagnosis] makes you not want to do anything because you can’t commit to anything can you because I know I’m going to have to go in for my treatment shortly. Like the courses, I wouldn’t mind getting on a course for basic computers or something and probably going for an IT job, you know, just answering phone, surely I can do that, but you can’t commit to nothing. You’re up in the air in a way, do you know what I
mean, you’re just living day by day until like it gets sorted out sort of thing” [Kevin, age 42, follow-up]

Therefore, the disease status of ‘addiction’, and thus the extension of the ‘sick role’ to dependent drug users, has the potential to provide dependent drug users with a range of benefits. Receiving a diagnosis of drug dependent – a condition or disease which has been defined as chronic, relapsing and not so dissimilar to other chronic and relapsing diseases (NTA, 2002; WHO, 2009) – inevitably places dependent drug users within the sick role. The dependent drug user becomes a client or patient, he participates in a ‘clinic’ where he receives his ‘dose’, which is given to him by a nurse under the supervision of a doctor. Referring back to Parsons’ definition of illness behaviour, the addict’s craving for drugs is legitimised through the use of substitute medication such as methadone. According to Parsons (1951) a person who is sick cannot be expected to fulfil normal social obligations, and is not held responsible for their illness. Therefore, the ‘sick role’ not only has the potential to legitimise dependent drug users’ offending behaviour but also exempts them from fulfilling normal social obligations such as maintaining employment. At the most basic level, the ‘sick role’ enables dependent drug users to deny responsibility for their behaviour by attributing activities such as offending and being unable to maintain employment to their sickness, thus explaining and neutralising their otherwise deviant behaviour (Sykes and Matza, 1957). Furthermore, for some dependent drug users occupying the social status of ‘sick’ is a wholly more positive role than the one of ‘homeless’, ‘jobless’, ‘smack head’ with a ‘criminal record’. The idea that a dependent drug user might want to remain ‘sick’, therefore, seems quite logical.

However, in turn for these benefits the sick role assumes that the sick person should want to get well, and to this end, must seek and cooperate with medical help. The sick role, therefore, indicates that the person who makes an effort to get well will be granted a social status of sick and will be able to access the benefits of that role. The irony is of course, as this chapter will demonstrate, that efforts made by dependent drug users to access the ‘sick role’ and remain within it produces an asymmetry between the ‘expressions they give’ and the ‘expressions they give off’; an asymmetry which not only denies dependent drug users
the benefits of the ‘sick role’ but further discredits and reinforces their already stigmatised identity.

Desires to make changes to their current chaotic lifestyles were consistent features of the expressions that the dependent drug users of this study ‘gave’ often suggesting that being a drug user is “no life”:

"I don’t want to have to go out shoplifting and shit like that, I don’t want all that, I’m 40 now, I don’t need it" [Wayne, age 40]

"I don’t know, that you’ve just had enough of it, just living this, it’s just existing, you don’t live, it’s a shit existence" [Zoe, age 35]

"I used to be out every day doing the Issue but I found it was a waste of time because all you do is you get your money and you just go and buy drugs and it’s just a continuous circle, you know, and you don’t end up having no food in the cupboards, you don’t end up with no clothes, you don’t end up going nowhere besides back to work and back to deal, you know, it’s no life" [Kevin, age 40]

"I didn’t want to be what I was, I didn’t want to be a druggie" [Reece, age 30]

“I realise it’s not going to happen overnight, it’s a long drawn out process kind of thing, but that’s my final aim, to be drug free” [Jim, age 60].

However, as the discussions that follow demonstrate, efforts made by dependent drug users to access the ‘sick role’, and remain within it, suggest they do not want to get well, they do not seek treatment and when they are in treatment they fail to comply.

6.4.1.1. Getting well

Before examining the extent to which dependent drug users wish to ‘get well’ this section must firstly set out exactly what ‘getting well’ means in the context of drug dependency. In the UK the process of assessing need for drug misuse and dependence is governed by both Models of Care (NTA, 2006) and the UK guidelines on clinical management (Department
of Health, 2007). Together the two documents provide a framework that informs drug workers about how individuals who misuse drugs should be assessed and the needs which should be addressed. ‘Need’ is defined as falling into one or more of the following domains (Department of Health, 2007:27):

- **Drug and alcohol use**
  - Drug use, including types of drugs, quantity and frequency of use, pattern of use, route of admininistrate, symptoms of dependence, source of drug (including preparation), and including prescribed medication and tobacco use.
  - Alcohol use, including quantity and frequency of use, pattern of use, whether in excess of safe levels and alcohol dependence symptoms.

- **Physical and psychological health**
  - Physical problems, including complications of drugs and alcohol use, blood-borne infections and risk behaviours, liver disease, abscesses, overdose, enduring severe physical disabilities and sexual health.
  - Psychological problems, including personality problems or disorders, self-harm, history of abuse or trauma, depression and anxiety and severe psychiatric co-morbidity. Contact with mental health services will need to be recorded.

- **Criminal involvement and offending**
  - Legal issues including arrests, fines, outstanding charges and warrants, probation, imprisonment, violent offences and criminal activity, and involvement with workers in the criminal justice system, for example probation workers.

- **Social functioning**
  - Social issues, including partners, domestic violence, family, housing, education, employment, benefits and financial problems.
  - Childcare issues, including parenting, pregnancy, child protection.

Clearly ‘need’ is recognised by policy makers and advisors as more than just ‘drug dependence’. However, the guidelines (2007:25) also emphasise the “the range or hierarchy of goals” with the ultimate goal of all treatment being abstinence from their drug of choice:

For some years now, “a range or hierarchy of goals” of drug treatment has been identified in the UK (DH, 1996):

- Reducing health, social, crime, and other problems directly related to drug misuse.
• Reducing health, social or other problems not directly attributable to drug misuse.
• Reducing harmful or risky behaviours associated with the misuse of drugs (for example, sharing injecting equipment).
• Attaining controlled, non-dependent or non-problematic drug use.
• Abstinence from main problem drugs.
• Abstinence from all drugs.

Similarly, the 2008 drug strategy recommended that:

“The goal of all treatment is for drug users to achieve abstinence from their drug of dependency” (HMSO, 2008:28).

And the 2010 drug strategy emphasised the government’s goal to enable individuals to become drug-free:

“Our ultimate goal is to enable individuals to become free from their dependence; something we know is the aim of the vast majority of people entering drug treatment. Supporting people to live a drug-free life is at the heart of our recovery ambition” (HMSO, 2010:16)

Thus, according to policy and guidance rhetoric ‘getting well’ means becoming abstinent from all drugs. According to McKeganey and colleagues (2004), abstinence is also the aim of the majority of service users attending treatment, and only small proportions identify harm reduction changes as treatment aspirations. As acknowledged previously, the expressions that the dependent drug users of this study ‘gave’, certainly supported this observation.

In a recent and insightful article, however, Neale and colleagues (2011) challenge what drug users mean when they say they want to be abstinent or drug free. The term abstinence, they argue, remains a poorly defined concept:

“When drug users say they want to be abstinent, we do not necessarily know what drugs they are talking about – all drugs; only illicit drugs; or only drugs such as heroin and crack cocaine…Also does abstinence really mean no drug use at all or only controlled drug use? And when are individuals talking about being abstinent – now and forever; now but not in
the future; or not now but in the future. Those in treatment may want to be free from all prescribed opioids, but they may also recognise the benefits of taking them in the interim” (Neale, Nettleton and Pickering, 2011:192)

Similarly for this study, expressions made by dependent drug users to be maintained on a methadone prescription suggest that becoming drug free, now and forever was an unrealistic and, for some, undesirable goal of treatment. While some participants expressed a desire to stop using illicit drugs, abstinence from all drugs remained an unrealistic goal:

"Yeah, I just want maintenance on that until I know I’m ready...that’s it, just general maintenance, no reduction, just leave it at that, because last time it hit me, them reducing me, I ended up bang at it again, then they had to titrate me back up" [Wayne, age 40, follow-up]

"Well, I want to bring it [the methadone] down, and gradually, hopefully, I don’t want to be on it this time next year...[I don't think it's realistic], not when I think about the times I’ve been on it before and how long it’s taken me to get down" [Kevin, age 40]

“I kind of didn’t expect too much but I wanted a prescription, a methadone prescription because I knew that I could get stable again then. I just wanted to get stable and try and sort of move things on from there really” [Jon, age 34, follow-up]

“I’m not even looking to come off the script because I think that is just silliness. I mean I think you need a good while on a script and living as normal as you possibly can just taking your methadone every day instead of trying to come off that as well as everything else, do you know what I mean?” [Marie, age 33]

Similarly, Claire described how her initial goal when presenting to treatment was "Just to get a methadone script that was all really". And when asked if she had any intention of becoming abstinent from all drugs she replied:

"I don’t know really, I did but it’s hard in the long run because I know that [my partner’s] not going to do it, so if he’s not going to do it I can’t, I’m not going to be able to do it myself. It’s sort of like waiting until he’s ready, which we’ve done with the crack, you know, one day turn round and, you know, I’ve had enough of it and it stopped. And the same with the heroin now, we're down to a bag a week. So it’s paying off but it's, I know that,
you know, I’m going to be with him for however long and I know I can’t do it while I’m with him, so it’s a case of take it as it goes, each day as it goes” [Claire, age 34, follow-up]

Few of the participants involved in this study expressed a desire to stop using drugs completely, and those who did acknowledged that abstinence was a long term goal, something to aspire to, but not a goal that can be reached immediately, upon presentation to treatment, as Cara, Jamie and Michelle explain:

"I’d just like to start on my treatment and come off that as soon as possible and be totally clean...last time when I done it they gave me, they said within three months, we’ll have you off everything, we’ll have you clean, so hopefully this time it’ll be about three months, maybe a bit less...If it’s not three months, it’ll be four. Some people are on subutex or methadone for years and I don’t want to do that, I just want to get totally clean” [Cara, age 22]

"My overall goal, for want of a better word, is to become completely drug free, I’m 30 in December and I don’t want to be, even though I’ve stopped taking illegal drugs, I don’t want to be dependent on anything really, but as I say I’m just trying to take it one step at a time, but my overall, my end goal is to be completely drug free, you know, from any drug whatsoever” [Jamie, age 29]

"I’d just be dead happy if I could stay off the drugs, stick to me script, and eventually I want to get it minimised, get it reduced and get off the god damn methadone” [Michelle, age 35]

Rather than being concerned with abstaining from all drugs immediately, participants attending treatment for their drug dependency expressed concerns about their ability to perform everyday activities and obligations such as having a holiday or having a stable place to live:

"Well, like, you see at the minute I’m doing alright, I’ve got me flat sorted out, I’m not offending, I’m going away in a couple of weeks, I’ve not been away in years, you know what I mean. I used to go away all the time, you know, every year so things are starting to get like a bit of normality going on. So, looking at this time next year I should be wanting to do voluntary work for these, do you know what I mean. I want to be doing something like that" [Laura, age 33]
"[My main problem] obviously is housing " [Jim, age 60]

Others expressed concerns about their mental health, as Stuart and Adele explained:

"Well, at the moment one of my workers, they’re trying to talk me into going into a rehab but I don’t think I’d be able to hack it and I don’t think I’d be able to stand it as well, you know, how can I put it? Erm, what’s the word, I don’t think I would be able to go through it all, you know, because once I start doing something and I get part of the way through it or half way through it I just end up messing up" [Stuart, age 39, follow-up]

"No, I’m just, I want it reduced but I need to sort my depression out first, that’s like my main focus but no one seems to be taking me seriously... I’ve not really thought about asking them here because you don’t see Drs here do you." [Adele, age 36, follow-up]

The need to address accommodation and health related problems was also recognised by key workers, as Janet, a probation service worker, and Bill, a substance misuse liaison worker, explained:

"And whilst, if they’re not in stable accommodation, how do you expect anybody to be stable? I can’t imagine not having a home to go to every night. So they just stay stoned, they just stay off it half the time because then it doesn’t matter, it doesn’t hurt as much" [Janet, Probation Service Officer]

"I mean if I was a client and I’d got a drug problem, all right, yes I’ll come to [the drug team]. I’ve got a drug problem, but I’ve also got nowhere to live and I think I’ve got hepatitis and got a bad chest, you’ve got to go your GP and see a district nurse maybe, got DVT, you’ve got a hospital appointment with a consultant there, you’ve got an appointment with your drug worker and you’ve got to go down to Housing Options as well. Yes but I really feel depressed about it, oh you go to [the local mental health team] as well on your way round....And then you’re asking me to go to work" [Bill, Substance Misuse Liaison]

In the absence of such problems being addressed some of the participants could not imagine a life without drugs, as Kevin and Wayne explained:

"I think it’s more like wanting something to do, you know like, being bored sat in my house, you get excited about it’s going to be your pay day and you’re gonna get a score... you know
you can go out that morning and you’re guaranteed to have a good morning, you know what I mean, where every other day you’re waking up to nothing” [Kevin, age 40]

"Well, that’s all I’ve known all my life, it’s either one thing or another thing and the crack isn’t a calmer, it’s an upper, the heroin, you know what I mean, you just don’t give a shit, and the diazies, they just chill you out, and you can think, you can think how can I get some money. Without the drugs all I can think about is that I’m gonna be £80 a week down in eight weeks time, I’m gonna be £80 a week down, I’m not gonna be able to live. We’re gonna get our house taken off us. There’s just no way we’re gonna be able to live, I don’t know, the drugs, they take all that worry away” [Wayne, age 40, follow-up]

This evidence firstly identifies a problem relating to how ‘getting well’ might be defined within the context of dependent drug use. If ‘getting well’ means abstinence from all drugs, as is suggested by UK drug policy and guidance, then the expressions that dependent drug users give off, such as wanting to be maintained on a methadone prescription and being more interested in resolving issues relating to mental health, housing and other health related problems, suggest that they do not want to ‘get well’. Moreover, accessing and remaining within the sick role potentially provides them with a ‘series of legitimised exemptions from the fulfilment of normal expectations’ (Parsons, 1964:113) in relation to those everyday social obligations and relationships that they feel unable to perform (such as the maintenance of stable accommodation, employment, and good relationships with others). Conversely, ‘getting well’ will require the dependent drug user to confront and address the negative social and psychological impacts of problems such as poverty, homelessness, unemployment and mental disorder.

Therefore, ‘getting well’ is an unrealistic and, for some, undesirable goal of drug treatment. Instead, the priorities for many of the drug using participants involved accessing and maintaining stable accommodation, reducing offending, and resolving mental health problems. This thesis is not suggesting that drug services do not work with drug users to address these problems. However, the priority for the services involved in this study seemed to relate to addressing the drug dependence first and foremost, with many of those needs mentioned above left unresolved as illustrated in the following two case examples:
Case Example 6.1

Stuart

At his first interview [February 2009] Stuart was aged 38 and had been using substances since the age of 12. He had received numerous episodes of treatment, his latest one being as a consequence of a Drug Rehabilitation Requirement which he had been given in October 2008. At his first interview he had been in treatment for approximately four months. When asked about his expectations of treatment at this time Stuart made clear that what he most wanted out of treatment was:

"A peace of mind, sanity " [Stuart, age 38]

However, in a follow-up interview with Stuart 12 months later it became apparent that his mental health problems had still not been resolved:

"I don’t really go out. I don’t go out at all, I stay in, because my depression is getting… Well, my depression is up and down at the moment. If I go out I always make sure that I go out with somebody, if not I just stay in" [Stuart, age 39, follow-up]

This was corroborated by his drug worker a month later:

"I’ve got him booked in for a medical review with one of our doctors but I think the main one for Stuart was the [criminal justice mental health] \(^2\) team because there seems to be one person is saying, this is wrong with him and somebody else is saying, it’s not and he doesn’t seem to feel he’s going anywhere. He’s not getting the medication he feels he should have” [Tim, Senior Substance Misuse Practitioner].

And yet his drug worker was making plans to transfer him to shared care:

“I have a date actually for his handover, which might benefit him because the GP is closer to his home than I am” [Tim, Senior Substance Misuse Practitioner]

\(^2\) A service which aims to deliver an integrated package of care to mentally disordered offenders who have additional needs, for example drug/alcohol needs
Plans to transfer Stuart to shared care were being made despite the level of support Stuart felt he needed and indeed was receiving from agencies such as the criminal justice mental health team:

"Basically they help me with coming to appointments and that lot, to see psychologists. I saw a forensic psychologist to see why, I’m diagnosed with post traumatic stress disorder and that lot, and self harm and that lot, and I’ve just got to wait for a follow-up appointment so they’re just helping me. It’s only a short term length of time that they help people but I’ve gone over that but I think they’ve renewed it...About eight month now. It’s a six month short term thing but like I said I’ve gone over that six months but I think they’ve renewed it so, just to basically help me with my psychiatric needs, and housing and all that" [Stuart, age 39, follow-up]

“If I need the help just call on [criminal justice mental health team] or [drug worker], or people at [the drug team] or Salvation Army. I’ve got quite a few people behind me now” [Stuart, age 39, follow-up].

Moreover, at his follow-up interview Stuart’s accommodation appeared to be quite unstable:

“I was kicked out [of NACRO] through drug abuse and erm, well basically I had like pipes and that in my room so they kicked me out, I ended up homeless, went into town and then ended up in Salvation Army and I’ve been in Salvation Army since” [Stuart, age 39, follow-up].

And yet, his drug worker was unaware of his housing problem:

“I’ve heard no comments about that” [Tim, Senior Substance Misuse Practitioner].
Case Example 6.2

Adele

At her first interview [March 2009] Adele was aged 35 and had been using heroin since the age of 19. Like Stuart, Adele had received numerous episodes of treatment, her latest one being a consequence of a DRR which she had been given in April 2008. At her first interview, therefore, she had been in treatment for approximately 10 months and was receiving a 50ml prescription of methadone. When asked if she was satisfied with the treatment she was receiving:

"No, I’m just, I want it [my prescription] reduced but I need to sort my depression out first, that’s like my main focus but no one seems to be taking me seriously... I’ve not really thought about asking them here because you don’t see Drs here do you." [Adele, age 35]

Yet her drug worker’s response to Adele appeared to be limited to the provision of a methadone prescription. When asked if her worker spoke to her about her mental health:

"No. I said I don’t want to ask my Dr because I feel like I’m not going to get anywhere and she said right well we’ll see how you are on your methadone script because that might change your mood and then come and see me again. Anyway, I’ve been asking and asking and I still haven’t had an appointment with the Dr there to see if they’ll prescribe me them" [Adele, age 35]

And still, 16 months later at her follow-up interview, Adele’s mental health needs were not being recognised:

"It’s not so good, I suffer from depression anyway but it’s getting worse. Well they’ve just been giving me my prescription basically and asking how are you going and poking their nose in." [Adele, age 36, follow-up].

As with Stuart, housing was a major problem for Adele. At her first interview Adele described dissatisfaction with her housing situation:
"I've spoke to them about my housing but they've done nothing, you see [the person I’m living with] he's an alcoholic, so you can imagine living there can’t you, I mean he’ll get pissed up three times a week and he’ll be a complete arsehole so there’s been times when we’ve just left, me and [my boyfriend], we’d just go, and we’ve slept in barns and everything just to get away from him, do you know what I mean, and it’s causing arguments between me and my partner because we don’t like it there, we don’t want to be there. [My worker] knows yeah. They tried to get me in the women’s hostel but then I wouldn't be with [my boyfriend] so that’s no good" [Adele, age 35]

Yet, when asked about what had happened to her accommodation at the follow-up interview:

"Nothing, my old probation officer, he’s just left but he was trying to get me in a women’s hostel, he was trying to get me in there but that’s not worked out...I went for an appointment, for an interview, but because there were too many people who were on methadone, I weren’t allowed in there...I think it’s one of them if your face doesn’t fit they don’t want you in there, to be honest" [Adele, age 36, follow-up]

Furthermore, when asked about what she receives from her worker in terms of support, she replied:

"Just my script really, I don’t get anything else" [Adele, age 36, follow-up]

"I’ve not had any benefit out of it at all. I’ve been here for like nearly three years now and I’m no better, when I was in [another area] I was off my meds, I was off everything, but I mean in the space of eighteen months, maybe because I had a stable home then and stuff like that but I got a lot, lot more help down there than what I do here" [Adele, age 36, follow-up ]

Despite the guidance provided by the NTA (Models of Care Update, 2006) and Department of Health (UK guidelines on clinical management, 2007) stating that client needs should be assessed across the four key domains of drug and alcohol misuse; health (physical and psychological); offending; and social functioning (including housing, employment and relationships), the drug workers presented in these case examples, at least from the perspectives of their clients, appeared to do little to address or resolve these issues. Instead,
the workers in these cases focused on the ‘treatment’ of the drug dependence. Yet, as already established by examining the expressions that dependent drug users ‘give off’, resolving their ‘drug dependence’ seems somewhat low down on their list of priorities. Rather, the dependent drug users of this study prefer to remain within the ‘sick role’ until issues relating to mental health, homelessness, and unemployment can be resolved. The irony is, of course, that showing very little desire to ‘get well’ creates an asymmetry with the expressions that dependent drug users give in terms of them wanting to change their currently chaotic lives, thus discrediting and throwing doubt upon this projection. It follows then that dependent drug users might be viewed as not wanting to ‘get well’ which may be construed as a failure to take responsibility and therefore judged negatively reinforcing further the stigma attached to drug dependency. Therefore, the stigmatised identity that dependent drug users are trying to transform by remaining within the sick role persists.

In order to avoid the development of inaccurate conceptions of dependent drug users symmetry must be created between the expressions that dependent drug users ‘give’ and the expressions they ‘give off’. To create this symmetry the notion to ‘get well’ must encompass both the dependency and the psycho-social problems which so often coincide with drug dependency. Therefore, service providers need to initially provide drug users with the means to confront and address issues surrounding mental health, accommodation, and unemployment as only when these types of problems have been resolved can dependent drug users begin to think about abstaining from drugs and vacating the ‘sick role’.

In addition to having a desire to ‘get well’, Parsons (1951) argues that individuals accessing the ‘sick role’ must also seek and cooperate with technically competent medical help. Like the desire to ‘get well’, however, it appears that the expressions that dependent drug users ‘give off’ suggest that they neither seek nor cooperate with competent medical help, thus producing additional asymmetry with the ‘expressions they give’ and resulting in further failure to fulfil the criteria of the ‘sick role’. 
6.4.1.2. ‘Seeking help’

Central to the concept of ‘seeking help’ is the notion of motivation. Flavo (2010:101) argues that most people do not want to be sick, and most people do not view the ‘sick role’ as a positive role to occupy. Therefore, those who are sick will be self-motivated to get well. However, despite good intentions to make changes to their current chaotic lifestyles many dependent drug users often lack the self-motivation to get well that might exist within those people suffering from other chronic and relapsing diseases such as cancer and heart disease. In fact, many of those individuals accessing drug treatment often do so as a result of external pressures.

Individuals who misuse drugs may make contact with drug treatment through a variety of service providers, which may be providing interventions across the various tiers of the drug treatment system, as Beverley, a senior substance misuse practitioner remarked:

“anybody can refer, we get referrals from GPs, hospital, NACRO, you know, if they've got a key worker and they’ve identified they've got a substance misuse problem they’ll refer”
[Beverley, Senior Substance Misuse Practitioner].

However, according to the most recent NDTMS figures (Roxburgh, Donmall, Wright and Jones, 2011) the most common routes into treatment for clients in 2010-11 were referrals from the criminal justice system (30%) and self-referrals (38%).

It is been argued that those entering treatment from the criminal justice system lack the necessary internal motivation to present to treatment voluntarily (Miller, 1991; Farabee, Nelson and Prendergast, 1993; Anglin, Prendergast and Farabee, 1998). Jenny, a 43 year old polydrug user of twenty seven years accessed treatment through a DRR and indicated that she would not be attending appointments had she not been given such an order, suggesting a lack of internal motivation:

"They are yeah, they are useful, I’ve done a group before and it did help me in the past but at the same time it’s also stress that I can do without, having to get all the way down here, do
you know what I mean? I don’t think that I’d be coming if it wasn’t a case that it’s an order that I’ve got to go to this group, I wouldn’t be on it. It’s just that I’ve got to go” [Jenny, age 43]

Jamie indicated that he had rarely ever referred himself to treatment:

"I was just referred, the majority of time from the police station to an appointment that I had to attend to get me into treatment. I’ve had quite a few self referrals. Well to be honest, the majority have been because of when I’ve been arrested, I’ve been referred to treatment, and it was either take the treatment or go to prison basically, you know” [Jamie, age 29]

Similarly, Jim admitted to using drugs problematically since the age of 25, yet his first experience of treatment was at the age of 50 which resulted from a referral through the criminal justice system:

“the only proper treatment I’ve had has been for heroin, my methadone, that’s like ten years ago, I got here through probation” [Jim, age 60]

These statements imply that within drug treatment there exist a number of individuals who may not have accessed treatment had they not been encouraged to do so by the criminal justice system. However, those accessing treatment ‘voluntarily’ may have been subjected to similar external motivation or pressures. Motivation, for example, manifests itself in various guises, as Bean (2004:229) suggests:

In a different form it [coercion] occurs also outside the criminal justice system, rarely do offenders enter treatment free of all forms of coercion, whether from friends, relatives or others. To talk, therefore, of ‘coercion’ and compare this unfavourable with ‘voluntary’ decisions to enter treatment is to be too optimistic about the nature of many drug users’ lives.

According to Marlowe and colleagues (1996) motivation, and coercion in particular, is a multi-dimensional concept and pressures to enter treatment may stem from a range of sources, including family and financial concerns as well as the criminal justice system. Kevin, Cara and Joe, for example, attributed their ‘self-referral’ to family and loved ones:
"I had a girlfriend and a couple of kiddies, I had a daughter by this time and a son on the way. So I had to buckle down" [Kevin, age 40]

"My mum’s booked a holiday for this year, well my dad’s booked a holiday for me, my mum and her [little girl] so I can’t, my mum or dad doesn’t know anything about it you see so I can’t go on holiday, I can’t do anything because I need to be at home to have the gear everyday. And her as well because she starts school soon and I don’t want to not be able to take her to school some days because I’m ill" [Cara, age 22]

“My mum told me I couldn’t carry on living there rent free while I was using...She was kind of OK with me using, as long as I paid for it with my own money and paid my board and stuff but my brother wasn’t happy with that at all because he used to be a user but at this point he’d just given up. So my mum then said to me, well because of [your brother] you’re going to have to go back into treatment or I’ll kick you out. I wasn’t in any position to kind of live on my own, so I went back to the CDT and got put on a pretty hefty methadone script, 50ml. I’ve been on that treatment programme ever since." [Joe, age 29]

Similarly, when talking about the referral to his first treatment experience Wayne describes how it was his dad who took him to treatment:

"The first time I got treatment was from the CDT, I think I was about 18 at the time for heroin and amphetamines, my dad took me because the heroin was getting way out of control, I’d put my family through a lot of stress and things like that so he took me there so they started me on a methadone and diazepam script, that was the first script I had" [Wayne, age 39]

Therefore, despite expressions to make changes to their current chaotic lifestyles the expressions that dependent drug users ‘give off’ suggest that they do not actively seek treatment of their own accord. Instead, they are coerced into treatment as a consequence of external pressures from both within and outside the criminal justice system.
6.4.1.3. ‘Cooperating with technically competent medical help’

Flavo (2010) suggests that while most people do not view the ‘sick role’ as a positive role to occupy, some are also dissatisfied with the social role they occupy, and may view the sick role as preferable. Flavo (2010) also argues that as a consequence of this preference such individuals may be less motivated to follow recommendations that would help them to recover and return to their normal social role and obligations. An individual’s motivation, therefore, to retain their sick role may be greater than their motivation to get well. For example, although individuals may engage in the socially acceptable behaviour of seeking medical advice, they may sabotage the treatment plan by not following recommendations made by their clinician.

The previous section suggested that many dependent drug users enter treatment because of an externally induced crisis usually in the form of pressure from family, friends, loved ones or the criminal justice system. Treatment, therefore, becomes almost unavoidable. According to White (1990:143), “when treatment becomes unavoidable, the addict will seek to achieve the treatment with the lowest frequency of contact, the shortest duration of contact, and the least intensity required from the treatment experience”.

Indeed, the participants of this study appeared, at least on some level, to comply with treatment expectations – they were, after all, attending appointments at the time they were recruited to the study. Upon closer examination, however, various types or styles of treatment compliance emerged.

‘Saying the right thing’

The first style of treatment compliance was ‘saying the right thing’. Those users who ‘say the right thing’ were characterised by often expressing a desire to stop using drugs but miss appointments or at least fail to comply with the requirements to, for example, access detox or rehabilitation. Adele, often talked about detoxing from alcohol but regularly missed appointments, as Ann, her keyworker described:
"Very hit and miss with her appointments, even though she was on an order of the court. In the process of the appointments she was with me, she was involved in quite an abusive relationship, she was drinking copious amounts, not attending her appointments, didn’t want to engage, all she was actually interested, she’d come in for her prescription, didn’t want to stay, wanted to get off and she’d turn up late, so you couldn’t actually see her. I didn’t think she engaged at all, at all well. We made appointments for her to come in because she talked about alcohol detox, I think she had two or three appointments to see the medic over at the CDT, she didn’t attend those, even though she’d asked for them, she didn’t attend them" [Ann, Drug Intervention Programme Manager]

Similarly, Jamie made requests for detoxification and rehabilitation but consistently failed to attend appointments, as Margie, his keyworker explained:

"He had a couple of major blow outs and realised that the only way he was going to get forward, because he offended again and he got a new order, came back to us, but he came back saying that this time he wasn’t going back to his partner until he’d got his act together and cleaned up because of the children. So claimed he wanted detox and rehab. I assessed him, and we took over [his treatment]. No problems with coming here for the first few appointments, came up on time, but was referred to the recovery centre as the first step to showing engagement for moving on into detox, missed every single one of those appointments and then last week didn’t collect his script" [Margie, Senior Substance Misuse Practitioner]

**Remaining in contact only**

The second style of treatment compliance emerging from the data was ‘remaining in contact only’. Those service users who ‘remain in contact only’ often attend appointments but do very little else and may even use illicitly on top of their substitute prescription. Stuart, who was on a methadone prescription at his first interview reported using both crack cocaine and heroin almost on a daily basis:

"I was using it everyday but in the past, well over the weekend I didn’t use any crack cocaine, I just had heroin, and that’s good for me that. But I had some crack cocaine this morning, didn’t have none yesterday, or Monday (today is a Wednesday) erm but I have had the heroin, obviously because I’ve got a heroin habit but I am on methadone but because I’m
using on top of my methadone I need my methadone putting up so then I can draw back off the heroin” [Stuart, age 38]

At the follow-up interview twelve months later very little had changed for Stuart:

"Just the same, crack cocaine and heroin but I smoke and inject it but I’d rather smoke it more than inject it...I only use about two or three times a week now. My drinking gone right down now so yeah, my drinking gone down" [Stuart, age 39, follow-up]

Similarly, Kevin described how when he was on a buprenorphine prescription he often used illicitly on a weekly basis:

When talking about his subutex script: "[nothing] happens, So I thought that’s the way for me to go, you know what I mean, but that back fired on me cause I’d get paid on a Thursday and I’d stop taking my subutex on a Monday so I’d get a hit on Thursday, how mad’s that you know what I mean, why I’d even think of that, I just don’t know [laughs]” [Kevin, age 40].

Jamie also described how previously he had been receiving treatment but also using illicitly on top:

"I carried on getting treatment but I just used on top of it so it was all just a waste of time really” [Jamie, age 29]

**Passive complier**

The third style of treatment compliance was the ‘passive complier’, referring to those who appear to be complying by adhering to all rules within the treatment milieu and meeting the minimal expectations set for them, but do little else that might help them to recover. While addressing issues from the past can be essential for recovery (ASPEN Education Group, 2009) Reece explains that talking about his past was the last thing he wanted to do:

“[My drug worker] she referred me to someone around [structured counselling service] but when I went to see her, she was like a psychotherapist or something, I just couldn’t like, do
it, I mean I just couldn’t do it. I just didn’t want to drag it all up again I suppose” [Reece, age 30]

Such lack of initiation was corroborated by Reece’s drug worker, Graham:

"In some ways he’s motivated. I mean he comes in here probably two or three times a week at the moment, you know, basically wanting help with this, that and the other, which is good in a way. But in other respects he’s kind of, it’s probably just a lifelong thing but, you know, if you set something up for him he often doesn’t actually follow it through. So he’s a mixture, you know, if you said to him, well what you need to do is you need to bring a load of paperwork in with you next time, he’ll come in again but he won’t bring the paperwork, you know, so that you can ring the gas board or whatever it is” [Graham, Senior Substance Misuse Practitioner]

For some dependent drug users the treatment episode does not provide an interruption to their use of illicit drugs. Such individuals continue to use on top of their substitute prescription while others either simply fail to comply or do very little to initiate their own treatment and recovery. Such lack of cooperation produces further asymmetry with the expressions that dependent drug users ‘give’ in relation to their expressed desires to make changes to their current chaotic lifestyles. Failing to comply with treatment discredits and throws doubt upon such projections reinforcing further their stigmatised identities. Such expressions also result in the failure to meet the final obligation of the ‘sick role’, the obligation to cooperate with medically competent help.

6.4.1.4. Getting well, seeking help, and complying with treatment

Chapter 3 established that despite the ‘disease’ status of drug dependence, the ‘sick role’ fails to legitimise the deviancy of dependent drug use. Neither does this status excuse dependent drug users from the normal expectations in relation to everyday obligations. Rather, and as a result of changes in drug policy, the increasing alignment between medicine and the criminal justice system (observed in Chapter 2), and the official and media discourse surrounding drug use (observed in Chapter 3), dependent drug users are held responsible for their addiction.
So far this chapter suggests that in an effort to transform their stigmatised identity, dependent drug users make attempts to remain within the ‘sick role’. Access to the sick role potentially provides them with a ‘series of legitimised exemptions from the fulfilment of normal expectations’ (Parsons, 1964:113). To become abstinent from all drugs now and forever, on the other hand, requires dependent drug users to confront and address the negative social and psychological impacts of problems such as poverty, homelessness and unemployment. Remaining within the ‘sick role’, therefore, has a number of benefits. While for many people the sick role is a negative role to occupy, for the dependent drug user it is a somewhat more positive role and suggests a departure from their identity as ‘thieving junkie scumbag’ (Radcliffe and Stevens, 2008).

Despite the expressions made by the dependent drug users of this study to make changes to their current chaotic lifestyles, the expressions they give off suggest that they do not do their very best to get well; fail to seek treatment of their own accord; and obstruct their own and their key workers efforts towards recovery. They may regularly miss appointments or fail to take the advice of their key workers in terms of lifestyle choices, apparently on purpose. Such expressions not only result in the failure to meet the sick role criteria but also, and importantly, produce an asymmetry with the ‘expressions they give’ thus discrediting and casting doubt upon their projections to make changes to their current chaotic lifestyles. Consequently, their already stigmatised identities become reinforced rather than transformed, preventing access to treatment and ultimately recovery.

Interestingly, this kind of behaviour supports the claims made by Auld and colleagues (1986) suggesting that dependent drug users are not passive victims of addiction and neither, does it seem, are they passive in receipt of their treatment. Allowing individuals to access the ‘sick role’, however, does seem to have a detrimental effect on recovery. It appeared that the dependent drug users of this study could not consider becoming drug free, not simply because they do not believe it in their power to change and cannot rationally decide or resolve to do so as Pearce and Pickard (2010) argue, but because of the negative
social and psychological impacts of problems such as poverty, homelessness and unemployment that remain unresolved in their lives.

6.4.2. Transformation through abstinence

Two of the drug users interviewed had become abstinent from all drugs. In comparison to those who were still receiving treatment for their drug dependency, Joe and Susan both departed from the ‘sick role’ and transformed their identities using rather different techniques. Joe became part of the drug treatment workforce seeking to help others to achieve recovery, while Susan left the world of drugs and drug treatment behind, a process often referred to by some authors as ‘distancing’ (McIntosh and McKeeganey, 2000; Gibson, et al., 2004; Radcliffe and Stevens, 2008). The way in which Joe and Susan transformed their identities are illustrated in the following case examples.

**Case example 6.3: Joe**

Joe aged 29 at his first interview began using heroin at the age of 17. After a series of failed treatment episodes and a conviction of theft from his employer he received a probation order requiring attendance at a drug treatment agency. He was given a 50ml methadone prescription and soon reduced to 20ml, which was eventually changed to a 60mg subutex prescription. Within 12 months he became abstinent of all drugs. At his first interview, Joe was in the early stages of recovery and still felt that he was being constantly judged, in a negative way, by others:

"that I’ve still got lots of confidence issues because I mean like I said that about being an outcast, I always think now that people will think the worst of me, even when you know new people that don’t know anything about my history, I still, I’ve just got used to people kind of not trusting me and thinking the worst of me” [Joe, age 29]

He was also finding it difficult to make new friends because of his previous ‘smack head’ identity:
"It’s kind of like once I was viewed as a, I mean they have a saying, once a smack head, always a smack head, and it’s kind of like that. It’s kind of like you’re outcast and everyone in the town knows who you are and it’s so hard to make new friends because you’re always viewed with suspicion" [Joe, age 29]

At his second interview (12 months later) Joe was facilitating a SMART recovery group – a self-empowering addiction recovery support group - in his local town and was employed as a volunteer manager for a local service which helps to provide people with practical information and support they need in order to address their drug and alcohol problems. When asked about experiences of stigma, Joe no longer referred to his own experiences but instead referred to the experiences of his clients:

"Some of the agencies start to panic about letting people with drink and drug problems loose in their service. Maybe panic is not the right word but they start to like kind of, you know, they’re very behind the concept but when it comes to the crunch. For example, the services that take on volunteers, they’ve kind of said, unless people are one year clean, and two years without committing any crime then they’d be very reluctant to take them on. I had a similar message from some of the education places, although they’ve said they would take them on. They said if they had any issues, then we’d need to tell them about all these issues, you know, they’d have to keep a close eye on it and stuff like that because, I mean some of them take on vulnerable adults and stuff like that. I mean I suppose it is safeguarding but it can be a bit frustrating at times. You tend to know, once someone’s been kind of clean for four months, you can see the change in them sometimes and it’s very hard to say, well you’ll have to wait for eight months before you can do this because of their rules. I mean I experienced that myself, you know, and it’s kind of well what do you do in those eight months?" [Joe, age 30, follow-up]

During his second interview, no longer were Joe’s replies to my questions about him and his recovery but instead about the recovery of others. He described himself as a ‘voluntary manager’ and placed emphasis on the responsibilities he has and the achievements he had made within the service:

“ I’m the volunteer manager, which involves quite a few different things really. The main
task that relates directly to that is to provide some form of supervision. So I mainly do that on a group basis once a week … another thing that it involves is the in-house training, which I spoke about, we do a training course for, the probation service want money to take on a few peer mentors to kind of work alongside the probation officers. So I put together a course in place for that, which has just finished and everyone completed. And now, I’m pleased to say, that they’ve immediately been assigned a probation officer and a client to work alongside, so that’s gone quite well. Because that role involves a lot more on the one to one side of things, those people will have some, not exactly clinical supervision, but something that’s closer to clinical supervision. So they’re doing that as well. There’s Smart Recovery Groups as well, although I say I go to one as a member but I also, the development of that, in terms of kind of, I get people referred in from like the detox nurse and stuff like that. So I handle all the referrals and the advertising and the setting up of new groups, I’ve just set one up in a supportive housing place. So I go down there once a week now and facilitate a recovery group there” [Joe, age 30, follow-up].

Moreover, during his second interview, Joe talked about his career aspirations in much more detail:

“I want to progress in my career and eventually I do want to earn a bit more money. I want to finish my degree and what I’m doing at the moment does help with that because it’s a work based thing, so you have to evidence what you’re doing and next year I’ve got to do some kind of human resource stuff, you know, do a few assignments on how you’ve dealt with a certain member of staff, you know, how you’ve helped them develop I suppose” [Joe, age 30, follow-up].

This detail was in contrast to that provided in his first interview where Joe seemed somewhat unclear about what he wanted to do:

“I’m not sure, I’m looking into it at the moment. I don’t know what the options are really” [Joe, age 29]

Case example 6.4: Susan

Susan aged 43 at her first interview began using heroin at the age of 18. Like Joe, she too had a series of failed episodes of treatment including inpatient detoxification and
rehabilitation but finally at the age of 42 she had a home detoxification with the help of the local community drugs team and became abstinent from all substances including alcohol. Similar to Joe, Susan became actively involved with the service user forum trying to help others recover from drug dependency. Eventually, however, she pulled herself away from drug treatment altogether.

The following statement illustrates how being involved in the service user forum eventually became quite a negative experience for Susan:

“[The service user forum] put on a teatime club, it was just full of service users, half of them were drunk, you know, we were expected to, they wanted to know why we were eating different food to them and I couldn’t protect people’s confidentiality. So in the end I just thought, I can’t do it in good faith. So I think they carried it on but it’s not going very well. It was just chaos, it was absolute chaos, and that’s what I found, the teatime stuff that [the service user forum] does, because the service users were either out their faces or pissed by teatime. So the breakfast club’s brilliant because they’re all, they have a breakfast and then go and do what they do, but there were fights breaking out and stuff getting nicked, it was mad. I just didn’t want to be associated with it. It’s too negative for me. The stress just makes you feel worse” [Susan, age 44, follow-up].

Susan continued to explain that she no longer felt she had the strength to deal with the problems of dependent drug users:

“My mindset has changed because I can’t be supporting drug users anymore, you know, and I’ve been doing that for three years. I know it sounds really harsh that but I don’t mean it like that, I don’t think that it’s for me and it’s just too draining. I’ve had my insides ripped out, you know, so I just don’t do this anymore” [Susan, age 44, follow-up]

When probed about why she is no longer involved in the support of dependent drug users, Susan described how she felt she had moved on and left the life of addiction behind, in other words, she had transformed her identity:

“I’ve been involved with drugs for a long time, a long, long time with addicts and I’ve moved on, my life’s nothing like that anymore, it’s not about that anymore. I slowly began
to feel that all the connections that I had were just wearing me down, you know, pulling me back to, that’s constantly and the amount of people constantly talking about addiction, people constantly talking about, and I suppose I used it when I first got clean to fill my time but I think it’s just a natural evolution… Some people want to work with addicts for the rest of their lives, you know, they need that contact, they need that interaction. But for me, I was questioning myself, why do I constantly need to, why do I need to reaffirm my sobriety by going and talking about being sober all the time, why do I need to do that? And the answer is, I don’t, you know, with or without group support I’m OK now and sort of grown away from it, I’ve moved on…I’ve got a second chance of a life, I don’t want to be tied to drugs anymore, I don’t. I want to be as far away from them as is humanly possible, without going to the moon. So yes, I’ve changed, you know, evolved.” [Susan, age 44, follow-up].

These examples illustrate how, eventually, some recovering drug users can manage to transform their identity. Joe did it through becoming actively involved in helping others to recover. Initially, this strategy was also used by Susan who managed the user forum for a number of years. Eventually, however, Susan removed herself from dependent drug users altogether explaining that this was no longer the world that she occupied. Susan no longer saw herself as a recovering user – as I suspect Joe did – she had moved on; she had transformed her identity.

6.5. Conclusion

This chapter has demonstrated that dependent drug users experience stigma from a wide range of settings. Importantly, it has been shown that stigma is also experienced from internal sources. Dependent drug users often perceive that they will be stigmatised, which prevents them from seeking and accessing services they might require. In addition, dependent drug users self-stigmatise resulting in them becoming isolated and withdrawn, creating further barriers for treatment progression and ultimately recovery.

The effects of such stigma are wide-ranging. In the public policy and health sphere the stigmatisation of specific populations often result in the view that certain populations are less ‘worthy’ and therefore ‘less eligible’ or ‘less deserving’ of services than other groups.
For example, users of illicit drugs are often viewed as ‘less deserving because their need results from addictive life choices rather than the perils of random health failure’ (Simmonds and Coomber, 2009:125). This is certainly the view of David Cameron, Prime Minister at the time of writing, who recently reported that “We are finding a large number of people who are on incapacity benefit through drug problems, alcohol problems and problems with weight and diet, and I think a lot of people who pay their taxes and work hard will think that’s not what I pay my taxes for, I pay my taxes for people who are incapacitated through no fault of their own” (BBC News, 2011).

Dependent drug users, however, do seem to make considerable efforts to transform this identity. It was shown in the previous section that those users in recovery transformed their identity by helping others to recover and eventually distancing themselves entirely from drugs and drug users. For those who are still in treatment, however, transforming their stigmatised identity was more challenging.

Many of the drug users interviewed for this study appeared to make efforts to remain ‘sick’. Being ‘sick’ and labelled as such has the potential to allow drug users to legitimise and remove their responsibility for otherwise deviant behaviour and excuse them from fulfilling normal social obligations such as maintaining employment. This chapter does not suggest that these individuals do not feel they need to alter their behaviour in some way. However, being ‘sick’ does have the potential to provide certain privileges, such as a ‘series of legitimised exemptions from the fulfilment of normal expectations’ (Parsons, 1964:113) in relation to everyday social obligations and relationships (for example, an inability to maintain stable accommodation, an inability to work, and an inability to maintain a good relationship with others). Being ‘well’, on the other hand, requires the dependent drug user to confront and address the negative and psychological issues such as poverty, homelessness, unemployment, and for some, mental health problems. The irony is of course, as this chapter has shown, that such efforts to remain ‘sick’ produces an asymmetry between the ‘expressions they give’ (i.e. the governable aspects of behaviour, such as expressions of desires to make changes to their current chaotic lifestyles) and the ‘expressions they give off’ (i.e. the governable aspects of behaviour such as accessing
treatment via coercive sources, and once in treatment failing to comply). This asymmetry not only assures that dependent drug users fail to meet the sick role criteria laid out by Parsons (1951), but also discredits and casts doubts upon the ‘expressions they have given’, reinforcing further their ‘sick-but-deviant’ identities. Thus, in order to avoid the development of inaccurate conceptions of dependent drug users, symmetry must be created between the expressions that dependent drug users ‘give’ and the expressions they ‘give off’.

The disease model of addiction and the label of ‘addict’ that is subsequently attached to dependent drug users not only implies that dependent drug users will not be held responsible for their deviant behaviour, but also places emphasis on the treatment of the drug dependency. Because drug dependency is defined as a disease, and because medical practitioners have been deemed as the most appropriate people to address such problems, dependent drug users are inevitably defined as ‘sick’. To ‘get well’, therefore, the disease of addiction must be addressed.

However, addressing the addiction and becoming drug free, as this chapter has shown, is for some an unrealistic and even undesirable goal. Instead, the priorities for many of the drug using participants of this study were to access and maintain stable accommodation, reduce offending, and resolve mental health problems.

To create symmetry between the expressions that dependent drug users ‘give’ and the expressions they ‘give off’, the notion to ‘get well’ must encompass both the dependency and the psycho-social problems which so often coincide with drug dependency. Service providers need to initially provide drug users with the means to confront and address issues surrounding mental health, accommodation, and unemployment as only when these types of problems have been resolved can dependent drug users begin to think about abstaining from drugs and vacating the ‘sick role’. Moreover, only when this symmetry is produced will the development of inaccurate conceptions of dependent drug users subside.
Chapter 7: Addressing the needs of the ‘sick-but-deviant’: The challenges and implications of multi-agency working in the treatment of drug dependency

“A mistress never is nor can be a friend. While you agree, you are lovers; and when it is over, anything but friends” [Lord Byron, English Poet, 1788-1824]

7.1. Introduction

Part II of this thesis so far has emphasised that, for various reasons, dependent drug users are often assigned to the somewhat hybrid status of ‘sick-but-deviant’. Despite being once regarded as an unremarkable part of daily existence in nineteenth century Britain, illicit drug use has become a phenomenon requiring control firstly by the medical professional and in more recent years by the criminal justice system. It has long been argued that drug dependency is a chronic and relapsing condition, which has biological, sociological, and psychological manifestations, and like other chronic diseases has no cure and requires longitudinal medical care (Saitz, et al. 2008). Illicit drug use, however, is also regarded by many as deviant, eliciting both legal and moral consequences. As Seddon (2011:417) argues, ‘since the mid 1960s, the drug problem has been recast as a matter of risk factors – whether in relation to the metaphorical ‘socially infectious disease’, a real contagious disease (HIV), or criminal victimisation – which needs to be monitored, controlled and managed’, and that medical practitioners have been deemed as the most appropriate people through which this action can be delivered (Seddon, 2010:3). Drug policy in the UK has ‘centred upon a discourse of prohibition, punishment and abstinence’ (Buchanan and Young, 2000:409); a discourse which is favoured by the UK Prime Minister, David Cameron, who, in response to the large number of drug users claiming incapacity benefit in the UK, recently suggested that that such benefits should only be made available to ‘people who are incapacitated through no fault of their own’ (BBC News, 2011), implying that addicts are held responsible for their condition. However, such a discourse is in direct
contrast to that used in medicine where individuals assigned to the ‘sick’ role are not normally held responsible for their illness.

To address the drug problem policy makers have focused their attention on a particular group of illicit drug users – the PDU population. This concept, introduced initially in 1982 by the ACMD, was intended to shift the attention away from the narrow medical model of treatment towards a more multi-disciplinary approach:

The individuals with whom the treatment/rehabilitation system is concerned may have various problems arising from the misuse of drugs or from drug dependency or both. These are not solely physical or psychological problems, but also social and environmental problems, being concurrently psychologically dependent on some drugs and physiologically dependent on others, and at the same time having financial or legal problems or difficulties over housing. The response to the needs of the drug misuse therefore requires a fully multi-disciplinary approach.

This approach should be problem oriented rather than specifically client or substance labelled. It would be similar to that in the field of alcohol where the term problem drinker has been defined by the Advisory Committee on Alcoholism. Thus, a problem drug taker would be any person who experiences social, psychological, physical or legal problems related to intoxication and/or regular excessive consumption and/or dependence as a consequence of his own use of drugs or other chemical substances (excluding alcohol and tobacco). (ACMD, 1982:34)

While the introduction of the concept PDU helped to drive the multi-agency approach it has nevertheless allowed for the formulation of ‘particular strategies and practice for the government of human conduct’ (Seddon, 2011:339). As Seddon (2011) shows, the meaning of the term PDU has significantly shifted since its 1982 introduction. PDUs have been defined in recent years as ‘those using opiates (e.g. heroin, morphine, codeine) and/or crack’ (HM Government, 2008:50), and ‘are of particular interest because it is estimated they account for 99 per cent of the costs to society of Class A drug misuse’ (HM Government, 2008:50). The focus of current drug policy, therefore, is ‘on those drug users who impose the greatest burden on the rest of society…now the aim is to target the most burdensome drug users, primarily through the criminal justice system, in order to provide
interventions which may reduce the costs their drug use imposes on society’ (Seddon, 2011:339).

Thus, it could be argued that the original intentions of the ACMD have never fully been realised. The definition of PDU provided by the ACMD in 1982 focused on the various problems that dependent drug users have, thereby promoting a multi-disciplinary approach to drug treatment. The definition of PDU provided during the 1990s and the drug policy which followed, however, focused on the social and economic costs associated with problem drug use, particularly with respect to the belief that much acquisitive crime was drug-related; in other words, was committed to finance drug use. Hence, the focus was no longer limited to the problems of drug users but on the potential harm that they could cause to the wider community:

“...It seems to us that there is now an onus on these [drug treatment] agencies to take a broader view and develop their focus to incorporate community safety as well as care of the individual drug misuser.” (Advisory Council on the Misuse of Drugs, 1994).

At the time of writing, crime reduction had become a driving factor in much drug treatment policy and practice, and the criminal justice system had become a key player in the provision of drug treatment, particularly its potential to provide a pathway into drug treatment (Department of Health, 1996), an approach that has attracted much criticism on the basis that the treatment needs of individuals have been neglected (McKeganey, 2005). Rather than emphasising the various problems dependent drug users have, the focus has centred on the problems they cause in society. The use of the term PDU, therefore, has emphasised the legal and moral dimensions of drug taking – from the medical dimension dependent drug users might still be regarded as ‘sick’ but their deviant status no doubt remains. Thus, when referring to a multi-disciplinary approach to drug treatment, the emphasis has been on the effective partnership between the drugs workforce and the criminal justice system rather than the drugs workforce and other health and social care services.
Nevertheless, both health sector and criminal justice workers who now have equally significant roles in the treatment of drug dependency are expected to work together alongside other agencies to address illicit drug use and the harms caused. However, this chapter suggests that the discourses and the complexity brought on by the need to address the ‘sick-but-deviant’ has important implications for such a multi-disciplinary approach and ultimately an individual’s access to services and their recovery.

This chapter turns back to many of the issues raised in Chapter 4. Drawing on the experiences of service providers interviewed Section 7.2 illustrates the centrality of multi-agency working in the role of the drug worker. In doing so, however, it also emphasises some of the difficulties that ensue when working with other agencies. Section 7.3 then provides an explanation for these difficulties by considering the effects of the most recent use of the term ‘PDU’ upon the role of the drug worker and the consequences this has for multi-agency working. This chapter will also illustrate the actions taken by service users and the drug treatment workforce to overcome the difficulties of multi-agency working.

7.2. Responding to the ‘sick-but-deviant’: The role of multi-agency working

It has long been established that to address the needs of dependent drug users, a partnership approach involving numerous agencies is required. This proposition was initially introduced by the ACMD in 1982 but has become a central feature of drug policy since. The 1998 national Drug Strategy (HM Government, 1998) recognised that, ‘because of the complexity of the problem, partnership really is essential at every level’. Similarly, the UK guidelines on clinical management (Department of Health, 2007:14) suggest that, ‘Many drug misusers have myriad health and social problems, which require interventions from a range of providers. Joint working across health and social care is therefore a key feature of effective treatment’.

Interviews with drug workers, probation officers and police sergeants revealed that working in partnership was regarded as a necessary and central function of their roles in the
treatment of dependent drug users. Karen, a nurse practitioner, emphasised that she could not fulfil her role as a drug worker or the needs of her clients without working with others:

"I could not work individually with a client without linking up with, I mean I can’t possibly do it all myself " [Karen, Senior Substance Misuse Practitioner, pg 15]

Similarly Graham, a senior substance misuse worker, insisted that the involvement of various agencies was necessary to meet the multiple problems presented by dependent drug users:

“There’re different aspects to people’s problems. So on the one hand I might focus mainly on substance misuse but there’re loads of other things like housing, employment behind that. So multi agency working is the only way really to give clients anything near to the service they need” [Graham, Senior Substance Misuse Practitioner]

Mike, a drug service manager, recognised that the complexity of problems presented by dependent drug users necessitated a multi-agency approach:

"You can’t deliver anything really, not much, to people with problems of the magnitude that they have via one agency and via one approach. There will be some people, some problems for who contact with one agency will suffice but that is rare because most people with drug or alcohol problems have a variety of physical and mental health social issues that will require input from a whole variety of organisations. So consequently, partnership work is inescapable and it’s desirable" [Mike, drug service manager, pg 2]

Keith, a drug coordinating sergeant, emphasised that multi-agency working is a central part of his role:

"Multi agency working, well it’s the core of my business, we work with every agency that there is, obviously the crime and disorder partnership’s very strong and very wide ranging. In relation to myself, we have some partners that we work with every single day, such as the Drug Service, the NHS, we deal with the Drug and Alcohol Strategy Teams, we deal with the local authority every single day, our paths cross every day” [Keith, a drug coordinating sergeant]
Despite the views presented by these workers, who accept the importance of a multi-agency approach to the treatment of drug dependency, multi-agency working remains fractured and limited. Beverley, a senior substance misuse practitioner insisted that while services generally work together quite well, working arrangements with some services remain problematic. For example, working relationships with the Community Mental Health Team (CMHT) and hospital admissions teams were identified as in particular need of some improvement:

“I think generally we work quite well, I think all agencies work well together. However, I think there are some areas that possibly do need some work and that would be the community mental health team. Because once we’ve referred to them we don’t necessarily hear from them again, which is a shame because we can support our clients and motivate them to keep going back, if we know that they’re not keeping appointments... The other thing I would say where we don’t work well together is with the hospitals. Hospitals will still discharge people without letting us know. Sometimes they’ve been in hospital and they’ve not even let us know that they’re in there so we don’t know how much methadone they’re on or what, they must be taking the clients word for it” [Beverley, Senior Substance Misuse Practitioner, pg 6].

The limited implementation of multi-agency working within the drug treatment system was also recognised by service users interviewed. Susan, a recovering drug user, commented that drug services in her area rarely make referrals to other services:

"They don’t refer you to anyone, they just, they do sometimes refer you to [the voluntary service] if you push but no, they don’t, all they want to do is get you in and out. There’s no links in with social services, there’s no links in with schools for your children, there’s nothing. There’s no links in with anyone." [Susan, age 43]

Conversely Sarah, a criminal justice treatment worker, insisted that in her client’s (Adele) case multi-agency working was successful:

"But I think as far as pathways are concerned in [Adele’s] case it really worked well, people were more than willing to move her through smoothly and quickly" [Sarah, criminal justice treatment worker]
Yet 16 months after her first interview, Adele had made little progress; she was still homeless, using illicitly on top of her methadone prescription, her depression was gradually getting worse and she began to drink alcohol to excessive levels:

“I’ve still got nowhere to live... I don’t think it was really an issue with alcohol last time, it was more my drugs but I’ve got a lot worse with my drink now. About 8 9% cans a day... [I have] about a bag and half a day...[and] I suffer from depression which is getting worse...I’ve not had any benefit out of it [treatment] at all. I’ve been here for like nearly three years now and I’m no, when I was in [another DAT area] I was off my meds, I was off everything, but I mean in the space of eighteen months, maybe because I had a stable home then and stuff like that but I got a lot, lot more help down there than what I do here [Adele, age 36, follow-up]”

Significantly, the lack of multi-agency working has been acknowledged in the 2010 UK drug strategy, *Reducing demand, restricting supply, building recovery: Supporting people to live a drug free life* (HM Government, 2010:5) emphasising that ‘although there has been some progress in tackling drug dependence, an integrated approach to support people to overcome their drug and alcohol dependence has not been the priority’.

While there is a wealth of literature identifying barriers to multi-agency working, there exists little research which pays “attention to the complex processes that may inhibit or facilitate such working” (Walklate, 2007:63). Vangen and Huxham (2006), for example, focus on issues relating to aims, culture, communication, power and trust; many of which were identified in this research. The issues that are not explored by the literature, however, are the possible explanations for such difficulties, which might be more specific to the subject area being researched rather than the stock of managerial or organisational theoretical explanations. The section that follows, therefore, seeks to explore the complexities brought on by the need to address the ‘sick-but-deviant’ and how such complexities have impacted specifically upon the role of the drug workers and their working relationships with other agencies.
7.3. The changing role of the drug worker: Impact on multi-agency working

While multi-agency working is regarded as necessary to treat the range of problems presented by dependent drug users, the complex issues that have emerged from emphasising their deviant status have inhibited such working practices. The focus of drug policy to break the so-called drugs-crime link and promote greater involvement of the criminal justice system in controlling problem drug use has forced what appears to be an unlikely marriage between health-oriented agencies and criminal justice agencies. Of course, as Seddon (2007) argues, the links between penal and welfare approaches were built in to the origins of drug control in the early twentieth century. Nevertheless, the contrasting institutional interests of the health oriented agencies around care, health and harm reduction and the criminal justice system, whose ethos is largely based on coercion and punishment, cannot be denied. It is this contrast, therefore, that makes the relationship that has been developed between these two agencies somewhat surprising. As with all marriages there has been an element of compromise, which has impacted on the role and practice of the drug worker, and ultimately their working relationships with other health and social service providers. Changing priorities and responsibilities have not only served to confirm the alliance that the drug treatment workforce has with the criminal justice system but have also helped to isolate them from other health and social care professionals, having an impact on their knowledge of referral pathways of services providing treatment or support relating to issues such as mental health, housing, unemployment and finance. Certainly, there has been some resistance to this alliance. For example, information sharing arrangements between some providers and the criminal justice system remain variable. Yet, refusing to share information has set to further problematise the treatment of non-criminal justice clients by making multi-agency working for this particular group of dependent drug users difficult; a difficulty which is further compounded by the divisions and conflicts caused by the abstinence/harm reduction dichotomy.
7.3.1. The changing priorities of the drug worker

A key objective of recent drug policy agenda has been to develop and enhance pathways between the criminal justice system and drug treatment services. The primary target group has been ‘problem drug users’ who are assumed to be involved in acquisitive offending in order to ‘feed their habit’. This group has, without doubt, become the central focus of a policy that has explicitly concentrated attention on offending drug users. Since the 1995 drugs strategy, *Tackling Drugs Together* (HM Government, 1995), the preoccupation of many developments in drug policy has been breaking the so-called drugs crime link and greater involvement of the criminal justice system in controlling the drug problem. This emphasis on crime continued under the 1998 drug strategy, *Tackling Drugs to Build a Better Britain* (HM Government, 1998), which focused on the development of new treatment initiatives accessed through the criminal justice system. Examples of these initiatives included DTTOs; community sentences involving both testing and treatment components supervised by the probation service, and the introduction of an integrated CARATS in the prison system. This arrangement of criminal justice interventions was brought together in 2003 within the DIP – an initiative which aims to coordinate treatment provision more effectively by working across the criminal justice system and providing an ‘end to end’ service for individuals. “Under the banner ‘out of crime, into treatment’, DIP has become a major policy programme in which central government has invested over £500 million in its first four years of operation” (Seddon, Ralphs and Williams, 2008:819), and by January 2008, over 3750 offenders a month were entering drug treatment through the DIP (UKDPC, 2008).

While insightful attempts have been made to explain these developments (Seddon, Ralphs, and Williams, 2008), little attention has been paid to the effects they have had on the role of the drug worker and, importantly, those receiving treatment. Historically, agencies within the National Health Service (NHS) have voiced unease in relation to allying themselves to the coercive treatment of drug misusing offenders, believing that it is an ethically inappropriate approach (Gibbs, 1999:285; Unell, 2002:229). Up until this point, drug treatment providers and the criminal justice system had existed independently with very
few points of intersection. Their reluctance reflected an underlying resistance to become involved in treatment therapy within a coercive setting and the low status historically accorded to health and social care within the criminal justice system (Duke, 2003). For example, the implementation of DTTOs (now DRRs) encountered many difficulties relating to the cultural, ideological and philosophical differences between the drug treatment workforce and criminal justice staff. The evidence presented in this chapter, however, suggests a move beyond this view has occurred, with many drug workers recognising a reduction in crime as an improvement in lifestyle and an important benchmark towards recovery.

The rhetoric to reduce drug-related crime, which has dominated much of the drug policy developed during the last 20 years, has had a marked impact on the role and practice of the drug worker, but only in recent years has this impact been the subject of research. One study examining what occurred in treatment sessions in mandated drug treatment concluded that work on therapeutic goals was hindered by short sessions and the conflicting activities undertaken as part of DRR sessions (Best, et al. 2009). Others have suggested that the drugs workforce has become criminalised and that their practice has become constrained by a criminal justice framework which is both rigid and punitive (Duke, 2010).

The priorities, responsibilities and activities appear to now replicate those of a criminal justice worker rather than those of a health provider. The priorities of the drug worker to treat drug dependency and its associated problems have, indeed, remained. However, the objective to divert drug using offenders from the criminal justice system into community drug treatment, while controversial (Stimson, 2000; Hough, 2002), has led to a reduction in offending being regarded as a key indicator of the success of drug treatment by policy makers, commissioners, and importantly here, drug workers, demonstrating their changing role from one which is focused on care, health and harm reduction to one which is focused on monitoring, control and management. This change has inevitably created some tension and has had implications for multi-agency working.

The multi-disciplinary approach to drug use which was promoted by the ACMD in 1982 has evolved into the establishment of a somewhat successful working partnership between
the drugs workforce and the criminal justice system. This partnership, this chapter suggests, appears to be relatively well-equipped to address the problems presented by those users presenting to treatment via the criminal justice system. The relationships with other health and social care providers, however, remain somewhat fractured and limited. Therefore, the service received by those referred into treatment from the criminal justice system appears to be more refined than non-criminal justice drug users.

Traditionally, the priorities of drug workers have focused on individual care, health, and harm reduction. In recent years, however, this priority has been coupled with the priority to reduce offending. Initially drug workers were resistant to the drugs-crime agenda which emerged under New Labour. This resistance was evident in the opinions of workers in the evaluation of DTTOs (Turnbull, et al., 2000). This resistance, however, no longer seems to be as prominent. Many of the drug workers interviewed as part of this study were accepting of the priority to reduce crime with some seeing it as a key indicator of the success of drug treatment.

There is little uncertainty about the priority of criminal justice agencies. The priority of agencies such as the probation service and the police is, without doubt, to reduce crime. Janet, a probation service officer, and Keith, a drug co-ordinating sergeant, both confirmed that the aims of their organisations were to reduce offending:

"We want, ideally, everybody to go to somewhere where they’re not offending, they’re stable and they’re not offending, that’s our, what we want as an agency". [Janet, Probation Service Officer]

"Well most of the aims are the same as what DIP says, you know, and we’re drifting that way even more now, is that we try and identify at an early stage drug using offenders in criminal justice and try and divert them away from crime through working with treatment. So due to the fact that we drug test people and due to the fact they have required assessments, my main role, as it is with all criminal justice agencies or all the agencies we work with, is just to reduce crime by identifying these people at the earliest opportunity...That as I see it is our main role, however we achieve that, the main thing..."
you’ve got to look at is always we’re here to try and reduce crime, whatever sort of crime it is, that’s the main role, to try and reduce crime.” [Keith, a drug coordinating sergeant]

Traditionally, such aims were not prioritised by drug workers and, even now, some drug workers rarely mention crime reduction as being a goal for them, focusing instead on a reduction in drug use and an improvement in living conditions relating to housing and employment, as Graham, a senior substance misuse practitioner with a background in probation work, and Fiona, a detox nurse, explained:

"Well first and foremost, as the title suggests as a Substance Misuse Worker, I’m talking with them about their substance misuse, that’s the primary responsibility I have, is to try and help them to reduce their substance misuse…but also they present with a lot of other problems, for example, housing or employment issues or relationship issues. So I talk with them about those kinds of areas and mental health may come into it as well" [Graham, Senior Substance Misuse Practitioner]

"Seeing, watching your kind of relationships grow, that’s always good, from meeting someone new and seeing progress, that keeps you going, and being able to just kind of like look at the little things and use them as a, you know, from someone kind of really anxious coming into treatment, to actually coming in and opening up to you, that’s a good thing” [Fiona, Detox Nurse]

This view, however, was not widespread with many drug workers and service managers recognising a reduction in offending as a positive outcome, as Margie, a senior substance misuse practitioner with a background in social work, and Bill, a substance misuse liaison nurse, explained:

"It’s emotionally draining working with them but that sense of, even if it’s just some little step forward, somebody not offending every day, I’ve got one lass down to, she’s not offended for a whole week and we’ve got her down to once a week from four or five times a day and she’s only injecting once a day now instead of five or six times a day. To me that’s a real buzz" [Margie, Senior Substance Misuse Practitioner]

“I’ve amended my views I suppose, in so much that, you know, we are achieving great things if we can stop somebody having yet another DVT, another hospital admission, or is
no longer offending, if we can stop those sorts of things, then we’re providing a pretty good service I think. If we can also get them off drugs that’s a bonus but many clients don’t come here, I don’t think they come here thinking, I’m going to get off drugs, they come in here because they’re using drugs and they’re withdrawing and they can’t cope with their lives… Their initial motivation to come into treatment quite often is, I’m rattling like hell and I can’t make ends meet and I haven’t got the money and I’m having to revert to crime, that’s often I think why they come into treatment” [Bill, Substance Misuse Liaison]

Similarly, Mike and Ann explain that while crime reduction may not initially be regarded as an aim of drug treatment, it is at least compatible with other aims:

"I think you have to accept that reducing re-offending is king in the world of drug treatment systems, it has been for many, many years, it’s just becoming more so, you know… I mean I am a believer in the benefits of drug and alcohol treatment, I suspect, well I know, that if you deliver the right kind of treatment to the right kind of person, you will see benefits. And the benefits will be a reduction in drug and alcohol use, you will see improvement in mental functioning, you will see improvement in physical health, you will see improvement in social functioning, including a reduction in offending. So I can live with it, you know, it’s fine by me" [Mike, Substance Misuse Service Manager]

“I suppose I hope that we’ve pushed, especially DIP, pushed it towards a much more humanistic approach and it isn’t just about the fact that, I know we’re supposedly, we’re here to reduce drug related offending, but we’re here to deal with people as well” [Ann, Drug Intervention Programme Manager]

Working relationships with criminal justice agencies also seem to have improved, representing a departure from the attitudes expressed by those participating in the DTTO evaluation (Turnbull, et al., 2000), as Ann, DIP manager and qualified mental health nurse, explained:

"when I first sort of came into this role it was very much, the worker that had had the job prior to me, it was almost a constant battle, with probation especially, so it was a bit of a poisoned chalice really. But over the years, I actually think we have worked together really well and we’ve developed some very good working relationships. I honestly think we have good working relationships with probation, we have good working relationships with the
court and the police, we’ve got operational police in here as well, so we have good
relationships with them” [Ann, Drug Intervention Programme Manager]

Drug workers and criminal justice workers communicate using a variety of approaches
including regular meetings and informal conversations by telephone and email, suggesting
an openness and informality that can only be achieved through a good working relationship,
as Margie and Karen described:

"Well the lead for offending is obviously probation and the offender managers and they
have their own groups and their own courses but we do, do three ways a lot of the time. So
we’ll sit down with the client and we’ll draw up a joint care plan where we agree what is
right for that client. Certainly, I think, there isn’t a week go by when I don’t hear from
every single one of the probation officers in the team I work with, often two or three times a
day. We’re on the probation system email, so we can get all the information” [Margie,
Senior Substance Misuse Practitioner]

"Probation tend to be quite good. Generally, if someone, because we have a lot of criminal
justice drug workers, if they’re within the sort of criminal justice, so say they’ve just come
out of prison or whatever, they tend to link up with their workers. Probation tend to be quite
good in that they’re always ringing us up to see if they’ve attended. But no, the problems
with probation, I don’t seem to have any problems with probation, I’d soon be on the
phone” [Karen, Senior Substance Misuse Practitioner]

Despite suggestions that ‘particular agencies and individuals will tend to promote one
aspect [of drug use] at the expense of another depending upon their philosophical viewpoint
and understanding of drug use’ (Buchanan, 2010:124) the evidence presented here suggest
that the priorities of the drug worker are no longer limited to individual care, health and
harm reduction. In fact, a reduction in offending has come to be seen as a key indicator of
the success of drug treatment. A priority once expressed exclusively by criminal justice
agencies, however, has become, after some years of resistance (as noted in Chapter 4), a
priority for the drug treatment workforce alike regardless of the various contexts and
backgrounds within which the various service providers were working. The continued pre-
occupation with the so-called drugs-crime link and the greater involvement of the criminal
justice system in controlling the PDU has eventually filtered its way through to drug
workers whose priorities are becoming increasingly aligned with the criminal justice system.

An agreement on priorities (aims and objectives) is a key defining feature of successful partnership working, a point which was illustrated in Chapter 4. Already it has been shown that the working relationships and communication lines between drug workers and criminal justice agencies seem to have improved. The priority to reduce crime, however, is not necessarily one which is shared by other health and social care agencies. It follows then, that the drug worker’s relationship with these agencies may not be as well developed, and this has implications for those dependent drug users who have not accessed treatment via the criminal justice system.

7.3.2. Responsibilities of a drug worker

The link forged between drug use and offending has had implications, not only on the priorities of drug workers, but also on their responsibilities. While drug workers are often trained to deliver psychosocial interventions, and despite the recognition that individuals who use drugs rarely present to drug treatment with a single condition, becoming embedded within the criminal justice system has refocused their attentions on the monitoring of attendance and, due to its success in reducing offending behaviour (Lind et al., 2005; Gossop, 2005; Millar et al., 2008), the dispensing of prescriptions for methadone. Explanations for this change in focus have been offered most recently by Seddon, Williams and Ralphs (2012) who suggest that the core work of criminal justice drug workers in particular is to communicate knowledge about risk to other institutions. This type of work, they argue:

“is concerned with the creation, production, processing, interpretation, distribution, sharing, reception or utilisation of knowledge or information. It can include form-filling, data entry, interviewing, data analysis or any other kind of information-oriented work” (2012: 124).
It is of little surprise, therefore, that many of the drug workers interviewed for this study reported having very little time to spend with their clients beyond that involving these type of activities. For example, Graham, Tim, Margie and Kelly all described how they had very little time to engage in any meaningful work with their clients:

“A number of my clients, I have to be honest, I do see just for a few minutes, and some it could be quite a lot longer but I rarely see anyone more than twenty/twenty five minutes... I don’t have the time to take things up to a deeper level with them. And it’s very, when you know that you don’t have the time to do that, you can’t half do it, you can’t start talking to somebody about perhaps having been abused and what that felt like or what that meant for them and then say, right, next time you come in I won’t have this amount of time” [Graham, senior substance misuse practitioner]

“I find the admin side and the recording and all of that has become bigger than the job, I’m spending more time doing that...” [Tim, Senior Substance Misuse Practitioner]

"I think probably I have a bit more commitment to the individual rather than to the number crunching and to the paperwork. Unfortunately, because of the way things are now, a lot of the emphasis is on making sure every bit of paper is done on time and to me it’s about the quality that you’re giving the client. You have to compromise because of funding issues etc, you’ve got to do the paperwork, sometimes it does seem to get in the way a little bit " [Margie, Senior Substance Misuse Practitioner]

"You’ve got more and more cases and less time to do the things that you have to do and then more kind of statistical stuff thrown in that that’s, you know, you’ve got to do. And all of that results in less and less time being able to spend with your clients really and less time to coordinate with things that you really need to do and liaise with other agencies really, those are the things that, you know, where the time is taken from inevitably” [Kelly, senior substance misuse practitioner]

The lack of time spent with clients is then reflected in service user experiences. Both Adele and Susan complained about their treatment experiences, reporting that their workers did not have the time to dedicate to them, often treating them in the reception of the service:

"Sometimes she’s given me my prescription out in the hall way" [Adele, age 35]
"Every time I went in it was just, there’s your script, not how are you doing or do you want to speak to anyone?" [Susan, age 43]

Therefore, the various other problems presented by dependent drug users, such as mental health, housing, skill deficits, unemployment, inadequate or anti-social support networks, and financial issues, are rarely addressed. The drug treatment workers interviewed for this research seldom felt it their responsibility to address the multiple problems presented by such individuals. A common response, therefore, was to make referrals to agencies that might be more equipped to address such problems. The reaction of such agencies, however, was not always favourable.

The drug workers interviewed were, by their own admission, rarely equipped to resolve mental health problems frequently necessitating a referral to elsewhere. The more severe mental health problems might require a referral to be made to the CMHT but often they refused to assess the client, explaining that their drug use must be dealt with before a full mental health assessment could be carried out. Jamie, aged 29 and father of two describes the response of the mental health team after an attempted referral:

"I’ve been referred to a psychiatrist in 2005, I tried to kill myself by injecting four bags of heroin and two £20 stones at once, I lost consciousness and everything but they brought me back around and put me in hospital and they referred me to a psychologist after that for a health assessment, a mental health assessment...She just put it down to the fact that I was so depressed because of my lifestyle because of the drugs, she said, mentally there’s nothing wrong with me, it’s just the drug use that’s making me feel so bad" [Jamie, age 29]

Similarly, Ann, a drug intervention programme manager, describes the response of the CMHT upon seeking advice about referring Adele who she believed was at risk:

"I referred her into CMHT to see if we could get her, because obviously when [her partner] died I felt that she was, she was obviously at risk, obviously at risk, I thought some extra support would have been beneficial. So I remember ringing CMHT to see whether or not there was any mileage in referring her in but they felt at the time that her level of drinking
was too much, that they’d be unable to work with her. So I didn’t get very far with that”
[Ann, Drug Intervention Programme Manager]

Other workers expressed similar difficulties in making referrals to the CMHT, as Sarah and Fiona explain:

"we refer to the community mental health team and it’s not easy to be honest because they tend to want people to address drug problems or, they’ll say if you’ve got a drug problem we can’t necessarily diagnose a mental health problem " [Sarah, Criminal Justice Treatment Worker]

"there’s always a difficulty with the community mental health teams because I think, you know, they see a lot of people with acute mental health problems, a lot more severe than perhaps we see day to day but occasionally when we do see people that we’re concerned about, it can be difficult getting them assessments because of the drug and alcohol abuse. And I suppose from our point of view, what we can sometimes see is that the drug and alcohol use has come from a mental health problem, that without that being solved, substance misuse can’t be resolved. But from their point of view they see a client intoxicated with false symptoms of mental health, she cannot be assessed properly without substance” [Fiona, Detox Nurse]

Some workers deemed mental health problems the responsibility of their client’s GP, as Beverley, Graham and Bill describe:

"The other thing is the general sense of, well why are we doing that work when actually he’s got a GP that, it’s his job to do that." [Beverley, Senior Substance Misuse Practitioner].

"Well the way that it works now is that if people have less severe mental health problems, for example, depression, anxiety, personality disorder and those kinds of areas, then we can book somebody into our doctor here, there’s a doctor here three times a week. And the doctor will probably give them twenty minutes or so of their time and might be able to make an assessment of somebody who’s depressed or they’re very anxious or whatever and would then write a letter to the GP. "[Graham, senior substance misuse practitioner]

"I think there is a lack of opportunities, shall we say, for people who you know need some psychological counselling of a specialised nature and it’s knowing what the best route is for
that. I sometimes refer them back to the GP because lots of GPs have a counsellor attached to them now... generally I think the trend is to try and get the GP to get involved in that, so they can monitor them as well and many GPs do, put them on anti-depressants” [Bill, Substance Misuse Liaison]

This form of response was also corroborated by dependent drug users. Cara, aged 22, described how she felt anxious when leaving the house yet when she explained her symptoms to her keyworker she was advised to seek help from her GP:

"Well that’s what they advised me to do as well, for my depression anyway to go and get something from my GP” [Cara, age 22]

Similarly Jon, aged 33, who reported having suffered from depression and anxiety since his early teens, described how his worker emphasised that he could not help with his mental health problems and that he had to seek help from his GP:

"[my drug worker] says they can’t really access anything like that, I’ve got to do it through my GP” [Jon, age 33]

Yet not all GPs respond favourably, as Jon explains:

“My GP always just says, we’ll deal with your drug issues first” [Jon, age 33]

Consequently, the mental health problems of many dependent drug users are left unresolved, as Graham described:

“[Referring someone to their GP] requires really is the client to then go and see their GP, follow things through...Now that sometimes breaks down because some of our clients don’t follow up with their GP or they don’t engage in the longer term and it breaks down” [Graham, Senior Substance Misuse Practitioner].

The following two case studies show how treatment progression and ultimately recovery can be affected as a consequence of unmet mental health need.
Case example 7.1: Kevin

At his first interview [January 2009] Steven was aged 40. He had been using substances since the age of 11 and started using heroin at the age of 22. He, like many other service users, has had numerous episodes of treatment, his latest one beginning in November 2008 as a consequence of a transfer from another area. Therefore, he has been receiving a methadone prescription since 2004.

In January 2009 Kevin talked about his expectations of treatment during the next 12 months:

"Well, hopefully I’ll have a good bill of health and hopefully I’ll have an IT job, and start going to the gym and doing a bit of swimming, a bit of lifting, do you know what I mean, just get my body in shape, I’ve abused my body for so long you know what I mean" [Kevin, age 40]

"I’ve joined the library because I can use computer there free of charge, so I’m gonna go on a basic computer course really just to learn how to do that" [Kevin, age 40]

And in relation to his methadone prescription:

"Well, I want to bring it down, and gradually, hopefully, I don’t want to be on it this time next year...I don't think it's realistic, when I think about the times I’ve been on it before and how long it’s taken me to get down, but if I push myself, you know what I mean and keep thinking I can do it and it’s all in my own head, which it is, I can achieve it. I’m not gonna say yes, 'cause you get let down and get yourself even more wound up don’t you." [Kevin, age 40]

Yet, in his follow-up interview in August 2010 Kevin had not attended any courses, had not gained a job nor significantly reduced his methadone prescription:

"I think I might have come down 10 mil since I last spoke to you or 20 mil, I think I was on 110, I’m on 90 now. I’m not sure if I was on 100 when I last spoke to you" [Kevin, age 42, follow-up]

Kevin’s key worker, Beverly associated his lack of progress with his mental health problems, which she felt were not being addressed:

"I mean we’ve talked about he wants to start college, he wants to do a short computer course. We’ve talked about agencies that he can get these things from but I just feel that without his mental health being addressed, that he’s never going to get up and go to these things, he’s just not got the motivation to do it" [Beverley, Senior Substance Misuse
Case example 7.2: Reece

At his first interview [January 2009] Reece was aged 30. Like Kevin he too had been using substances since the age of 11 and started using heroin at 21. Reece had a very difficult childhood; he had been sexually abused as a child, had a long-standing history of depression and anxiety and had been self-harming since his early teenage years. Again, like Kevin, Reece had received numerous episodes of treatment, his latest one starting in December 2008 as a condition of a license upon his release from prison in November 2008.

At the time of interview, Reece was receiving a Buprenorphine prescription to relieve him of cravings for heroin and generally expressed satisfaction with this treatment:

"It’s like me, I’m on the subbies now and I’m happy, I’m on a small dose and it doesn’t really affect my life, I can live a normal life you know and I do" [Reece, age 30]

He also had part-time employment as a chef:

“I work part-time on a Sunday. Just as a chef on a Sunday, doing Sunday dinners and that" [Reece, age 30]

The treatment he was receiving for his mental health problems, however, was more problematic. Reece had been referred to a psychiatric nurse several times with little success. At his interview in January 2009 he was waiting for an appointment from a psychiatrist who specialised in anxiety:

"[My drug worker’s] referred me to see this woman who I’m waiting to see who specialises in people who’ve had long term problems with anxiety and that" [Reece, age 30]

Reece’s expectations of his current treatment, therefore, were to:

"reduce my subutex and find some medication that helps me with, or find something that helps with my anxiety so I can sleep properly at night and stuff and be relaxed and not feel scared all the time, and that’s it basically but you know, [my worker] is doing her best. I think I’m quite optimistic in thinking that I will get help and I will eventually find out something that will help me, because you can’t cure these things can you but you can find things that can help you." [Reece, age 30]

Reece was interviewed again, six months later. His license period had ended and so did, it
seemed, much of the support he was receiving:

“I was really happy with the help I was getting when I was on licence and coming here, doing groups and everything, you know, it really helped me, that’s why I was doing so well because of all the help I had around… it all sort of stopped at once, so I sort of ended up on my own, you know, it sort of all hit me” [Reece, age 30]

His mental health seemed to have also worsened:

“Af...
Stuart, who had complained of hearing voices, was a recipient of this service:

"Basically they help me with coming to appointments and that lot, to see psychologists. I saw a forensic psychologist to see why, I’m diagnosed with post traumatic stress disorder and that lot, and self harm and that lot, and I’ve just got to wait for a follow-up appointment so they’re just helping me. It’s only a short term length of time that they help people but I’ve gone over that but I think they’ve renewed it" [Stuart, age 39, follow-up]

This service, however, is not available to those dependent drug users who have less severe mental health problems and/or are not involved with the criminal justice system, as Tim and Margie explained:

“Generally speaking the GP would deal with stuff like depression and anxiety, that’s a primary care thing. The [criminal justice mental health team] would be more interested in people with psychosis and, you know, that type of mental health. That’s not to say that they won’t, I mean only last week they assessed two of my clients, both of them with depression and their recommendation was that their GP picks up all that” [Tim, Senior Substance Misuse Practitioner]

"We’re very, very lucky because we’ve got a [criminal justice mental health team]. So if our clients have mental health problems, we can get them assessed by [that team], which is attached to the criminal justice system. And they have their own nurse prescribers and they have support workers, so they’ve got senior CPNs and they have access to a psychiatrist and a psychologist. So that’s quite a good team. They don’t work, generally speaking, with depression because that’s a GP’s job and we liaise with GPs over depression" [Margie, Senior Substance Misuse Practitioner]

Therefore, those dependent drug users suffering from common mental health problems such as anxiety, depression, phobia, obsessive compulsive and panic disorders, and are not offending often remain undiagnosed and untreated. These types of dependent drug users are ‘truly the people nobody owns’ (Prins, 1993) and are placed at the bottom of the social priority pecking order. Their mental disorder is not sufficiently problematic that it causes risk to the public, and neither are they offending. Hence, they are not considered a priority group. Consequently, their problems remain unresolved.
In addition to unresolved mental health problems, many dependent drug users also experience problems with housing, but again this is not an issue addressed directly by the drug worker. Referrals are often made to other organisations, as Beverley explained:

"We have links with the City Council, that’s who we would refer to. We do contact obviously other organisations, do referrals for our clients that are homeless, that sort of thing." [Beverley, Senior Substance Misuse Practitioner]

Yet in both East Town and West Town, dependent drug users involved in the criminal justice system are often assigned to a dedicated housing support worker. Mike, a drug service manager, explained how criminal justice clients receive more support in terms of housing needs:

"There’s a housing worker who is attached to the DIP, he’s fantastic, you know, but he only deals with CJS clients. If you ask me what my suspicion is about the housing conditions in which many of our service users live, the thousand patients that are open to us at any one time, many of whom are not in contact with the CJS and will not be eligible for the DIP service, I don’t know what they’re like" [Mike, Substance Misuse Service Manager]

It is somewhat difficult to deny the priority afforded to dependent drug users involved in the criminal justice system. Indeed, it appears that drug workers regard it their responsibility to address the drug dependency. However, if the dependent drug user is also an offender it seems extra resources are provided to address any additional needs that might be apparent, such as mental health and housing, a service which is not provided for their non-offending counterparts. The preoccupation with the so-called drug crime link and the resulting alliance between drug treatment and criminal justice agencies has resulted in drug treatment services, it seems, being more equipped to deal with the problems of criminal justice clients over and above their non-offending counterparts. For example, Fiona described how criminal justice clients are often prioritised; they are seen very quickly and are always offered appointments:
"Yes, I mean there’s a lot of pressure now, lots of targets, specifically on the criminal justice side, the clients get seen very quickly and they always do, they’re always offered appointments." [Fiona, Detox Nurse]

Consequently, some service users believe that a reduction in offending is the main priority for drug workers, as Jenny, a 43 year old drug user for 27 years explains:

"That’s what it’s all about really, they’re more concerned about offending, and as long as they’re giving you a prescription they’re not bothered, they’re not bothered" [Jenny, age 43]

Although drug workers should be trained in psychosocial interventions in accordance with NTA Models of Care their time is often taken up by activities similar to those carried out in the criminal justice system. The activities of the drug worker are largely based around monitoring attendance and dispensing prescriptions. Less time is available, therefore, for care planning, harm reduction and psychosocial or therapeutic interventions that are effective in improving outcomes for treatment. Consequently, drug workers often have little choice but to refer their clients elsewhere. The success of these referrals, however, seems to depend on the referral status of dependent drug users.

The partnership between the drugs workforce and the criminal justice system has meant that the problems of those posing the most risk to their wider community can be addressed. Across East Town and West Town dependent users involved with the criminal justice system will have access to a housing worker who can address any accommodation issues. In addition to this dedicated service, West Town also provides a service that can help with severe mental health problems, but again this service is only available for those who are involved with the criminal justice system.

The lack of partnership working between the drugs workforce, and CMHTs and housing providers, however, has meant that problems of dependent drug users not involved with the criminal justice system often remain unresolved.
7.3.5. Isolation of the drug treatment workforce

The apparent priority afforded to criminal justice clients is in direct contrast to the guidance issued by the Department of Health (2007:75) which explicitly states “Drug misusers in the criminal justice system should neither receive higher priority for their treatment nor should their legal status deny them access to care equivalent to that available in the community”. However, the aim to reduce offending may not be directly incompatible with the various other aims of drug treatment. If a reduction in offending is observed it is likely that improvements in other domains will also be observed. There is, of course, an unfortunate consequence of this direction in drug treatment, namely that drug workers who align themselves with the criminal justice system risk becoming isolated from other health and social care professionals:

‘…the growing alignment with criminal justice has actually only served to further isolate the drug treatment field from other related health and social care sectors delivering care and support to socially excluded people in the United Kingdom. We have grown adjacent to, but in relative isolation, from other key health and social care sector. Responding faithfully to a strong national lead, our centre of gravity has moved steadily and ever closer towards the criminal justice system. This movement has enabled the field to grow and prosper, but it has also served both to isolate us strategically and programmatically from key transformations at local level’ (Wardle, 2008:3)

Yet, it is these other health and social care agencies that deliver support for problems relating to mental health, housing problems, literacy, debt and unemployment. A multidisciplinary approach, therefore, is absolutely necessary to address the complex needs of individuals presenting to drug treatment.

There is no doubt that in order to address the needs presented by dependent drug users a ‘whole systems’ approach that relies on effective multi-agency working of a large number and variety of agencies is required, creating its own inevitable complexities. These complexities, however, are confounded by the drug treatment workforce’s isolation from such services, evidenced in the accounts of service providers participating in this study. Many service providers lacked knowledge about the various services available while others
complained about ambiguous referral processes, particularly with regards to CMHTs and housing providers.

There was a general lack of knowledge about who provides support for mental health, housing, education and employment. West Town, for example, had the benefit of a dual diagnosis service, yet when Beverley was asked about services for dual diagnosis she referred instead to GPs:

"I would suggest that that would be the doctor...there's nobody specific, not that I’m aware of" [Beverley, Senior Substance Misuse Practitioner]

The lack of knowledge about the dual diagnosis service among drug workers in West Town was further corroborated by the types of referrals received by the dual diagnosis service, as Phil, a dual diagnosis nurse, explained:

"I think the majority of referrals come from in-patient psychiatry. So the vast majority of those then are severe mentally ill clients. The next largest group is community or mental health services, specialist mental health services. Then the next biggest group, we've got designated as primary care and that is primary care mental health and GPs and the occasional health visitor or specialist midwifery. And then the next group is substance misuse services." [Phil, Dual Diagnosis Nurse]

There also appeared to be a lack of knowledge about the types of agencies that provide housing, educational and employment services. Bill explained how he had used such services in the past but was unaware of what was available in the present:

"We did have and we may still have, although I’ve not used her for a while, a woman that works for the College, further education opportunities for clients who want to tap into that. So it’s a very easy referral process for them to tap in to. Now whether it’s still going or not, I don’t know...Job Centre Plus are more linked into us now, they came late on last year and did a presentation, they’re now getting sort of a key worker involved with drug using clients who are getting benefits and are looking for work. Their remit, I gather, is to find them work, whether they want it or not. Housing... I think that’s probably one of the things that’s lacking in a way really, you know, you’ve really got to be on desperation road before they’ll
find you somewhere, you know, you could finish up in a Salvation Army hostel, you know."

[Bill, Substance Misuse Liaison]

In East Town some attempt was made to provide drug workers with information about the various services available through the use of regular visitor sessions. However, rather than a surplus of knowledge being gained, workers were often left confused, as Bill describes:

"The problem is we’ll get a lot of information about lots of different things, like any other service. You go to, like we do the visitor’s session, do the visitor’s session every six weeks, you always get different people from different agencies. You always find out more about each other every time. And I think everyone’s always really willing to share that, so the relationship I would say is good. There’s probably other factors that make the information and knowledge not as clear but not the relationship, more like the overload of information"

[Bill, Substance Misuse Liaison]

Being isolated from health and social services has also resulted in a lack of understanding regarding referral processes and assessment criteria. Many drug workers complained about the lack of clarity regarding the referral process to the CMHT. Bill, for example, described a situation where he became quite concerned about one of his client’s mental health, yet the CMHT would not agree to carry out an assessment, stating that the client would not meet their criteria:

“I had a guy who, he probably still does, he needed bereavement counselling, to actually try and get somebody in for that, it just seems a complicated thing. We had a guy who was referred to the community mental health team because he was talking about very alarming things around suicide. Now I’m a psychiatric nurse, so I’m not immediately going to get panicky about it… but at the time his mother had died, his dog had died coincidentally, which was very important to him, and I referred him to a community mental health team and they said he didn’t meet their threshold, sorry their criteria. What’s your criteria? Could I find out what their criteria was, no, I didn’t know what it was. And this guy was saying, nothing to live for, there were no protective factors and I went home quite worried about him… it made me think, what does a guy have to do or threaten to do or express the level of desperation before you’re going to be seen by a community psychiatric nurse and accepted in the community mental health team umbrella?... I reckon if you asked any drug worker here today, how do you refer somebody to psychological services, they won’t be
able to tell you and I don’t know. I wouldn’t know who to ring, I wouldn’t know what to
tell the client, I wouldn’t know what I could inform them of, of what they would expect
from that service, I don’t know...I don’t even know where they’re based...We meet a lot of
disturbed individuals here and, you know, you could argue their drug problem is the least of
their problems.” [Bill, Substance Misuse Liaison]

Similarly, Sarah describes confusion about the referral criteria for the CMHT emphasising
that she has never had one of her client’s taken onto their caseload:

"Not so easy, I find it a little bit confusing and maybe it’s because I’m not a mental health
nurse, I don’t come from that background and I’m never too clear about how to get
somebody some help, and I have made referrals a few times to the community mental health
team, I’ve never had one of my clients get taken on to their caseload...I had a girl which was
probably, we thought she had a personality disorder but was really erratic and depressed and
suicide attempts and really struggling and I thought it might have been a good idea to get
her a CPN so she had more people involved with her...She didn’t end up with a CPN, she
did end up getting a mental health assessment and a couple of them have had that. It’s been
when people have been suicidal and delusional that I’ve made referrals and they usually do
get a mental health assessment but none of the ones I’ve referred have ended up with a
CPN" [Sarah, Criminal Justice Treatment Worker]

As a consequence, there is some concern among workers that individuals who use illicit
drugs are not being treated for their mental health problems, as Bill explained:

"Are we just patching hands up here by giving them a substitute drug but not being able to
deal with the psychological element of it? I think a lot of them have got psychological
problems, deep seated, for many years, that have never been dealt with. Not just because of
lack of services perhaps but maybe they’re not ready to deal with them, like that guy,
bereavement counselling, I know he’s going to need it sooner or later but he’s not ready for
it but then again I wouldn’t know where would be the best place to refer him to, apart from
the GP. So there might be many reasons why they’ve not had a service, they might not be
ready for it but it might also, a big part of it is where does the drug worker refer them to,
how do they do it? It’s got to be quick and easy. If you’re seeing sixty clients in a fortnight
say, which some people are, thirty per week, if you’re motivated to refer them it’s got to be
easy and quick" [Bill, Substance Misuse Liaison]
The referral processes of housing providers were also unknown, as Bill and Janet, explained:

"I’ll be honest, I really don’t know what [the housing providers] do. I know what they’re supposed to do but I don’t know how it works and how they’re resourced and how many staff they’ve got or what their expectations are. It’s not just drug using clients that get referred I presume, it’s anybody who hasn’t got a roof over their head. I sent a chap down there once, very anecdotal this but, he normally, well he had nowhere to live, he was staying at friends’ houses, wasn’t on the street and their response to his housing needs was, go back to [the area you came from]. Well no, I’ve come down here because my family are down here. To me that wasn’t a solution and I know it wasn’t to him " [Bill, Substance Misuse Liaison]

"there are some agencies that it’s all got to be done by the book and, you know, it’s all about processes and filling in forms...Some are housing particularly, more of the supported housing, some forms, you look at it and think, oh do I have to? Whereas if we had a standard form, if we could just fill that in and send it to all housing agencies, which is what we used to do, but now they’ve all devised their own form. So that can be very draining. But housing more than anything, and that’s the main problem we have, I have to say." [Janet, Probation Service Officer]

Even Andy, the senior housing strategy officer for East Town remarked on the inaccessible referral systems of particular housing providers:

“We’re working with about 10 housing providers...Different views and different policies ...We have one RSL in particular, and you look at their eligibility criteria or you look at their, like debt is an issue, well what are the issues around debt, if someone’s got debt what do you want us to do, and there’s a whole page, you know, this is ok but this is not ok, it’s just so inaccessible, whereas others are much more straight forward, you can talk to an advisor or something, so it’s, that’s the challenge for us in terms of working with partners, so I think the challenge is overcoming that fear." [Andy, Senior Housing Strategy Officer]

Confusion about the referral processes of various agencies involved in the treatment of drug dependency were not limited to drug workers and probation officers. Beverley described how GPs are often confused about how to refer clients into structured day services:
"GPs will often ring up because they’re confused about how to refer somebody in for perhaps maybe some structured support or maybe some acupuncture or relaxation, you know, the systems change at times, sometimes it’s not always fed where it should be" [Beverley, Senior Substance Misuse Practitioner]

The changing priorities and responsibilities have helped to isolate the drug treatment workforce from other health and social care professionals. Drug workers, it seems, have little knowledge about services providing treatment or support relating to issues such as mental health, housing, unemployment and financial issues, and where knowledge does exist workers are often confused and uncertain about the referral processes.

7.3.3. Information sharing and communication

The closer alignment between the drug treatment workforce and the criminal justice system has had a clear impact on the priorities and responsibilities of the drug worker, which have isolated them from other health and social care services making referrals and ultimately multi-agency working difficult. This alignment, however, has had little impact on the level of information sharing between agencies. Indeed, for those workers involved in the supervision of drug using offenders, information sharing with criminal justice agencies had become the norm rather than the exception, as Graham explained:

"In general terms I think it’s a very good thing that there’s confidentiality boundaries because it gives clients a fairly clear basis for being prepared to be open about whether they’re using and what kind of problems they’re having. Where it causes problems is specifically at this office, is that the clients here are required to attend, as part of the court order, and once they buy into being on a court order, what comes with that is that we share with the probation service whether people are attending, whether they’re using on top and our general views about how people are progressing. And so there isn’t the same confidentiality arrangement at this office" [Graham, Senior Substance Misuse Practitioner]

However, for those working with individuals who are not involved with the criminal justice system information sharing remained a barrier to multi-agency working as Simon, a DAT manager, and Janet, a probation officer, explained:
"I don’t know, the most obstructive services I think are statutory services. I think local authority and NHS services tend to be the firmest gatekeepers and drug and alcohol use is often one of those opportunities to gate keep that more severely, which is why I work at, answering that earlier question, which is why I work at a sort of national and policy and strategic level to try and, you know, open some of those doors and change criteria for service...I think the engagement of health services complicates [multi-agency working], it brings great strengths in terms of what you can draw on and what you’ve got available, but there’s always been issues around information sharing, confidentiality, etc, etc, etc, which they can be worked around in some cases, compromises can be reached in others and sometimes people just need educating to be told, you don’t actually need that, why are you asking for it?" [Simon, DAT manager]

"With the Community Drug Team I have found it difficult. Because we’re used to working with Drug Services [who work specifically with criminal justice clients] and we just pick up the phone and go, hiya, de, de, de, when I had a client specifically who was still on supervision with me, her DRR had finished, her treatment was at the community drug team and I was still supervising her and there were serious child protection issues and the child ended up being taken away, but I was trying to speak to her drug worker and say, can you tell me what’s going on here because I’m in touch with social services. Well who are you and what do you want? And he’s probably doing his job, he was just a bit snotty about it, which was unnecessary. And I said, you know, you can check from [the criminal justice service] if the treatment was transferred and I’m working, de, de, but he was just really sort of, don’t be treading on my toes and telling me my job. And I wasn’t trying to tell him his job at all, I wanted to know what was going on. And I think because they’re not set up, linked in directly with probation, that can be an issue. They don’t want to disclose information and that’s probably absolutely right but where there’s child safety issues, that kind of overrides everything" [Janet, Probation Service Officer]

Non-statutory drug services appear to be even more cautious about sharing information, as Keith, a drug co-ordinating sergeant described:

"[Non-statutory agencies] they don’t sometimes understand that they can be more guarded about, more precious about, not the information they hold but about their client group, which makes it harder to work with them. And I understand that and that’s fine, you know, at the end of the day there are certain guidance and certain protocols that it’s only right that
they maintain, but in this day and age, when the one thing that everybody’s trying to do, whatever your agency is, if you’re a commission service, is to reduce crime. And then there comes a point where you just have to say, well if you’re not going to work with us on this, then we can’t work with you. So there comes a point when I think you’ve just got to realise it’s all about reducing crime. Yes it’s about protecting clients, yes it’s about helping clients, getting them to a better and healthier life, but the bottom line is it’s public money and public money wants reduction in crime” [Keith, Drug Co-ordinating Sergeant]

According to the Department of Health (2007:18) ‘information sharing can be of great value to the direct care of individual patients and may also contribute indirectly to the delivery and effectiveness of the drug treatment system’. Yet, information sharing protocols seem to be only in place for those dependent drug users also involved in the criminal justice system. Indeed, communication and information sharing arrangements, it appears, are commonplace for dependent drug users attending treatment as part of a court order. Often these users have both a probation worker and drug worker who communicate regularly and share information. Extensive communication and information sharing, however, is less common for dependent drug users who are not involved with the criminal justice system, potentially impacting on the care they then receive.

7.3.4. Ideologies

To conclude this examination of the role of a drug worker it is important to consider the treatment ideologies of the drug treatment workforce, and to explore how the consequences of these are expressed in practice. Recently there have been important debates regarding the professional ideologies of the drug treatment workforce and the overall goals of treatment. The practices of the drug workers in relation to long-term harm reduction strategies have been challenged by both practitioners and academics (McKeganey et al. 2004), leading to debates among those involved in the planning and delivery of drug services (Nelles, 2005; Martin, 2005; Roberts, 2005; Trace, 2005). As a consequence of these debates the concepts of ‘recovery’ and ‘social reintegration’ have been introduced and have encouraged the development of a social model of treatment that focuses on wider social and environmental factors in the treatment and recovery process. This emphasis requires drug workers now,
more than ever, to move away from individually focused models of change to more social work orientated practice. It also reiterates the importance of multi-agency working to help with the various aspects of a person’s recovery.

Despite this shift, the drug treatment workforce is still somewhat unsettled or unsure about what their practice should entail (Duke, 2010). For several years the drug treatment field has seen growing divisions between the abstentionists on the one hand and the harm reductionists on the other, and nowhere is this division more prominent than in the North West of England (Wardle, 2008).

Indeed, many of the drug workers interviewed for this study have invested in the ‘recovery agenda’ emphasising that it has been a goal of theirs for many years. Sarah insists that the aim of maintaining people on methadone was never something that she was entirely comfortable with:

"I was never really interested in keeping people maintained on methadone and that’s why I went more into GP liaison because I thought, well, you know, holistic approach, get everybody on board and hopefully they’ll make some progress and they won’t have to stay on methadone. It didn’t work out that way, I thought it would, not for everybody but for some people it does. So this whole new approach now, of moving them on and getting them out and the emphasis being on that is kind of more up my street." [Sarah, Criminal Justice Treatment Worker]

Kelly and Tim, senior substance misuse practitioners, also placed an emphasis on the importance of getting individuals into recovery, but acknowledged that not all drug workers have invested in these treatment ideologies:

"I’ve been here just over four years now and I’m just trying to think how many I’ve still got that I had at the beginning, there’s not very many at all, there’s probably only three or four. Usually I can discharge one a month, that’s the usual thing. I don’t think everybody does that but I try and at least discharge one a month, either because I’ve done the reduction plan with them or they’ve gone into an inpatient detox. I try and get as much turnover as I can really and I think that’s more about individual workers and the way that people will work. Because I know there was someone else who had a similar background to me in probation,
who started the same time as me, she left just a few months ago and she’d been here about
four and a half years and she’d only discharged about two people in that time. So I think
there’s definitely a difference in the way that some workers will push people into detox and,
you know, try and look towards the future rather than be thinking, why does this person use
drugs and what’s happened in the background and focus on that. I tend to try and shift
people towards the future." [Kelly, Senior Substance Misuse Practitioner]

"I’m sure there are others who are anti-recovery but I certainly see that as a good move by
the Trust...I think it’s just down to belief systems. I mean when I worked in the prisons, the	
treatment provided in the prison was determined by the doctor. I’ve had doctors come in
and we were doing a lot of Naltraxone and all of that, and a new doctor came in and said,
I’m not into maintenance and that was it. He didn’t believe in it, I suspect he was ignorant,
he didn’t know anything about it, so didn’t want to dabble, and it just meant everything
changed in the prison while he was the doctor. And I think some people, drug workers
maybe are the same but they don’t necessarily know about it and don’t see maybe how
different things, you know, it’s all like, we’re all small wheels and cogs of the bigger wheel,
everything is valid but I think recovery is seen to be something that works. As I say, the
prescription deals with the presenting, it stops you withdrawing, it stops you using heroin
but then you’ve got to get beneath that and look at contributing stuff. So yes, I’m all in
favour of recovery" [Tim, Senior Substance Misuse Practitioner]

Conversely, many workers maintained the importance of harm reduction emphasising
principles of safety, as Fiona and Bill explained:

"On the recovery side, when you first do the detox role, you want to be very encouraging
and give a really good review of recovery, how great it is, you know, and you can do it. But
on the other side you’re kind of thinking, well, look at this client, you know, stable, they’re
able to parent their kids, they’re managing their money, alright they’re on methadone but
actually they’re doing alright. And why should I be coming in and saying, get off your
methadone, knowing they’ll struggle. Keeping people safe has got to be the main thing
really hasn’t it? The actual safety and hopefully trying to protect the physical health long
term, so the education and the advice, trying to prevent deaths, overdoses, hopefully trying
to monitor mental health and just trying to improve the standard for life in some way and
giving them an opportunity to go into other agencies, even if it’s just the GP, where they
might be frightened to go or might feel like they’re being judged or whatever." [Fiona,
Detox Nurse]
"If you came, which I didn’t, but if you came into this service thinking all the clients I see I’m going to get them drug free, then you might as well give up because that isn’t going to happen. And I tend to work on the more holistic basis, if you like, am I going to help them improve their lives, am I going to help them reduce the amount of harmful substances that they’re using? Am I going to educate them about what injecting does and what the risks of overdose, harm minimisation, if you like? I’m more into that, maybe twenty years ago I might have been a bit more idealistic and naïve and thinking, I’m going to get everybody off drugs. And that is ultimately still an aim but in the real world, that’s the end goal but somewhere along that pathway you should be inevitably having harm minimisation and improving the quality of their life.." [Bill, Substance Misuse Liaison]

While divided treatment ideologies have been said to isolate drug workers from each other (Wardle 2008), there is the potential under the ‘spectrum of recovery’ for the approaches of harm reduction and abstinence to come together. White (2007), for example, suggests that the spectrum of ‘recovery’ should include both pharmacological therapies, such as opiate substitute prescribing and abstinence based approaches. An ideal definition of recovery, he suggests, ‘would be broad enough to embrace both incremental and transformative styles of recovery and consolidation’ (White, 2007:231).

Though the emphasis on the ‘social’ aspects of recovery and reintegration hold promise in terms of reducing the divisions and conflicts caused by the abstinence/harm reduction dichotomy, effective partnerships may still be hindered due to the focus of drug policy on addressing the drug-crime link. Therefore, transforming the drug treatment system would entail shifting the focus away from the criminal justice system, the activities of monitoring, and addressing the drug-crime link towards developing effective partnerships with service providers in the community, including health, housing, education, and training. As well as thinking about the reintegration of dependent drug users into local communities, policy makers and advisors should initially be thinking about ways in which the drug treatment workforce can be reintegrated in local community health and social care services to enable effective referral for issues such as mental health, housing and education. Only when such integration is achieved can a fully multi-disciplinary approach to the treatment of drug dependency be realised.
7.4. Responding to the changing role of the drug worker

The definition of PDU provided during the 1990s and the drug policy that followed has focused attention on the social and economic costs associated with problem drug use, particularly with respect to the belief that much acquisitive crime is drug-related. Hence, the focus of drug policy is no longer limited to the problems of drug users but on the potential harm that they could cause to the wider community.

The priority to break the so-called drug-crime link has resulted in the establishment of a somewhat successful working partnership between the drug treatment workforce and the criminal justice system. This partnership, as this chapter has shown, appears to be relatively well-equipped to address the problems presented by those users presenting to treatment via the criminal justice system. The relationships with other health and social care providers, however, remain somewhat fractured and limited. Therefore, the service received by non-criminal justice drug users appears to be less refined than the service received by those involved in the criminal justice system.

Dependent drug users and drug workers respond to these problems in a number of ways. This section demonstrates the techniques used by dependent drug users in an effort to receive a ‘better’ service. Also examined in this section are the techniques used by drug workers to provide a ‘better’ service and to enhance relationships with other health and social care services.

7.4.1. The responses of dependent drug users

This chapter has demonstrated that the focus of drug policy and treatment is disproportionately on the dependent drug user who is involved with the criminal justice system. These users appear not only to receive the very best treatment available but are prioritised for services such as mental health and housing; services which are equally as important for their non-criminal justice counterparts.
There are, of course, a number of unfortunate consequences of the priority afforded to dependent drug users involved in the criminal justice system, which are illustrated by the experiences of the users interviewed for this study. The following case example demonstrates the effectiveness of a DRR for Wayne. It also shows, however, the consequences of withdrawing support once such a court order has been completed.

*Case example 7.3.*

At his first interview [February 2009] Wayne was aged 39. He had been using substances since the age of 14 and started using heroin at the age of 18. He, like others referred to in this thesis, had received numerous episodes of treatment, his latest one beginning in September 2008. At this point he was given a Drug Rehabilitation Requirement and was provided with a methadone prescription. As part of this order, Wayne was also expected to undertake two drug tests per week and to attend a structured day care programme involving both one to one and group work sessions, requiring him to attend the drug treatment service almost every day:

“Since I’ve got this order, my drug use has reduced tremendously now, I’ve stopped using the cocaine completely, I come here more or less every day of the week now” [Wayne, age 39]

In contrast to his previous treatment experiences Wayne describes how the worker attached to his DRR appears to have a lot more time for him:

“Well you just got a script and that was it, I used to just pick my script up every fortnight, there was no counselling when you go and see your worker, they now ask you what you’ve been doing and that but there was none of that, you used to go in and pick your script up and that was it. Since I’ve been getting my script from here now, the worker that I’ve got here, we have half an hour talk, she asks me everything like what’s going on, which I’ve never had all the time I’ve had a script, I never had that with my drug worker”. [Wayne, age 39]

At this point Wayne’s treatment seemed to be going well and, with the extra support he was receiving by being on a DRR, he could envisage a future without drugs:

“Well when I get myself clean they help to stay clean, you know, something to show me
how to stay clean and not keep going back to it, which it seems to be doing, which like I say I haven’t used crack and cocaine, I think it’s been for 20 week or something like that, I can’t remember now, it’s quite a while. They’ve helped me through that, they’ve shown me how to stop that, I just need to do it with the heroin now” [Wayne, age 39].

Yet at his second interview [July 09], after completing his DRR, Wayne reported relapsing. He explained that he had started worrying about finances and was finding it difficult to cope without the support he was receiving when subject to a DRR:

“Things have just started to crop up again and I need help to get it sorted out, otherwise I’m gonna end up either dead or bang at it again… I’m just worried about the next coming month and how we’re gonna survive. I don’t want to have to go out shoplifting and shit like that, I don’t want all that, I’m 40 now, I don’t need it” [Wayne, age 40, follow-up].

Wayne’s experience is not exceptional. Reece also reported feeling unable to cope once his parole licence came to an end and, like Wayne, he too relapsed:

"It all sort of stopped, my mum left, my brother left and then all this [parole licence] stopped, it all sort of stopped at once, so I sort of ended up on my own, you know, it sort of all hit me. I just wanted to stay drug free and, you know, get on with my life and get a job. I was really happy with the help I was getting when I was on [parole] licence and coming here, doing groups and everything, you know, it really helped me, that’s why I was doing so well because of all the help I had.” [Reece, age 30]

Due to the increased support given to drug users involved in the criminal justice system many of those interviewed reported having specifically committed a crime to maintain the support they had as a criminal justice client, as Stuart explained:

"I did go out and commit an offence on purpose to actually get put on probation and a DRR. My head just went one day and I thought right, I need help, so I went out, I know it was the wrong way to go about doing it but I can’t really come to the probation office and go like that, can you put me on probation because, you know, the courts have to put you on it...I can be lazy, you know, so that’s why I went out and committed the crime to be put on probation and a Drug Rehabilitation Requirement but they were only gonna give me a six month one and I said to them that’s not long enough, I said to them I want longer so they retired and
come back up and they were smiling at me, and I thought, yeah, they’re gonna give me longer so they gave me 12 month on each” [Stuart, age 38]

Like Stuart, Wayne also asked for a DRR when appearing in court:

"I actually asked for it, I got told what it was and that it would help me with everything with the drug use" [Wayne, age 39]

Committing crime to maintain support is apparently common among clients, as Janet explained:

"And yet you get other clients, and one in particular, well he’s just completed his rehab but he had six months of doing nothing, he reoffended specifically to stay with me, how bad is that, which is a bit of a worry. He said, but I just felt like all my support was going, you know, committed a petty offence and requested at court another DRR. For him, I think, he suddenly started thinking oh that support is not now going to be there. They panic, I think so, I do. They take it for granted and when you say, you won’t have to come anymore they go, what do you mean, don’t have to come?” [Janet, Probation Service Officer]

The experiences described here demonstrate the vulnerability of dependent drug users leaving the criminal justice system. While subject to a DRR or parole licence the dependent drug users interviewed for this study received an intense treatment programme addressing their many problems. Once these orders were complete, however, the support structure they had as a criminal justice client was removed. Some of the dependent drug users interviewed here reported relapsing when their criminal justice order came to an end. Others simply reported employing the strategy of committing crime or at least ensuring arrest; a strategy that would guarantee their support was reinstated.

7.4.2. The responses of drug workers

This chapter has argued that the alliance created between the drug treatment workforce and criminal justice system has potentially created difficulties for multi-agency working with other health and social care providers. For example, formal systems of referral between
agencies have become almost impenetrable, impacting ultimately on the service received by non-criminal justice clients. In an effort to overcome these difficulties, and in line with the findings of Blau and Meyer (1971) discussed in Chapter 4, it was found that many workers sought to devise their own, relatively informal systems of multi-agency working, particularly when making referrals.

Graham, for example, used his previous experience as a housing worker to make referrals to housing providers:

"I refer people to the city council’s single homeless team, it’s open to me to make referrals directly to hostels if I know of some that might have vacancies. In my case I worked in housing for a while, so I’ve got some ideas about how to liaise with them directly." [Graham, Senior Substance Misuse Practitioner]

Similarly, Janet described how she used informal contacts to make referrals:

"I think it very much depends on the individual, I’ve got a good working relationship with a lot of people and you tend to use named people and they get to know you, and that then counts for a lot" [Janet, Probation Service Officer].

Janet also described how she made a housing referral for Jamie through the contacts she had at shared housing:

“I got [Jamie] an appointment with shared housing and the guy at shared housing, knows me and knows how I work with my clients. So he knows that my clients will, if he’s got problems he’ll ring me and I’ll say, hang on a minute, and I’ll pull them or I’ll go to a three-way. So for them my clients are a safer bet in some way because there’s somebody else then. So I took Jamie and he said I’ve got fifteen on my waiting list. So I said, well OK, and he rang me the next day and said, I’ll get Jamie in. And that was because Jamie was sleeping on his dad’s sofa and it was an over sixties one bedroom and he shouldn’t have really been there. So he helped me out in that regard. So, you know, with them I’ve got a good working relationship. I have with most people really." [Janet, Probation Service Officer]
Consequently, inconsistencies between workers are often encountered. Earlier in the chapter it was noted how Bill, a substance misuse liaison nurse, became very frustrated when trying to refer to CMHT. Conversely, his colleague, Kelly, a senior substance misuse practitioner with a background in social work (who has a desk next to Bill) describes the CMHT referral process as simple:

"you would just phone up and give some details and they’d come out and assess them for you" [Kelly, Senior Substance Misuse Practitioner]

Such inconsistencies are reflected in service users’ experiences of treatment, with the allocation of workers becoming similar to that of a lottery. Reece talked about his relationship with his key worker describing it as better than what he had ever received before:

"I think they’re really good, especially [my worker], you know what I mean, like I’ve done a lot of groups here and they’re all great you know. If you’re alright with them, they’re great with you. They’re dead nice to you, respectful and like, [my worker] just goes out of her way to try and help you. It’s not like, oh we’ll just get you to see a doctor and palm him off with meth, it’s not like that, you feel, ‘cause I’ve been through all that, I know when someone is knobbing me off you know what I mean, and I don’t feel like that with [my worker] and that, I just feel like if they can help then they will. It gives me a bit of hope, you know, that at least these want to help me to try and solve my problems, try and solve, if I want to help myself I know I can". [Reece, age 30]

Similarly, Claire and Adele compare their experiences of different workers describing one as much better than the other:

"The workers at SMS don’t seem to be able to give you the support you need, my key worker, she’s lovely, she’s heavily pregnant, she’s at SMS, but it seems to be, you see when I had my first experience of treatment, I’d have a full half an hour to 45 minutes, one to one session, whereas now because the workloads are that big you go in and you’re being treated in the corridor sometimes rather than in a room." [Claire, age 33]

"I don’t know, obviously because she’s always unwell, I don’t really get to see her. Like she’s not here today, do you know what I mean? I was alright with [my old worker], I
wanted to stay there with her but [my new worker] wanted me, so I ended up going there"
[Adele, age 36, follow-up]

The skills required to work effectively with other agencies are, therefore, reduced to technical competencies or taken for granted practices, as Janet and Bill explained:

“Training for multi-agency working, not really, well I’ve not been on any. I think it’s just something you pick up as you go along, you know, you make contacts with people, you do definitely...” [Janet, Probation Service Officer]

"But I think, I don’t know why, there’s probably lots of reasons, but there’s not many clients you seem to refer that eventually do tap into these resources that could help them. Now is it because there’s a prejudice against drug using clients or is it because they’re overworked or is it because we’ve referred to the wrong people? Maybe we should have referred somewhere else and we didn’t or maybe they just haven’t got the resources to deal with it, I don’t know" [Bill, Substance Misuse Liaison]

‘Multi-agency working’ for dependent drug users who are not involved in the criminal justice system relies largely on the informal relationships that have been acquired during the life of a drug worker. As shown here, such informal relationships were more apparent among those workers who had a background in some form of social work, reflecting perhaps the long standing history of partnership working in this area. The alliances developed with various organisations and agencies, therefore, are often selective and differ from worker to worker, sometimes depending upon their own previous backgrounds and experiences. There will be some workers who have established working relationships with CMHTs, making referral processes seem unproblematic. Others, as this chapter has shown, will not have established these relationships making referrals difficult. For the dependent drug user who is not involved in the criminal justice system, therefore, the service they receive and the problems that will then be addressed may ultimately depend on the worker they are assigned to.
7.4. Conclusion

Multi-agency working is no doubt difficult in any field. However, the need to address the requirements of the ‘sick-but-deviant’, a dichotomy reinforced by the re-conceptualisation of the term ‘PDU’ during the 1990s, and the complexities that have resulted, has only added to the already difficult task.

In an effort to shift attention from the narrow medical model of treatment towards a more multi-disciplinary approach, the ACMD in 1982 introduced the concept PDU emphasising the multiple problems presented by dependent drug users. However, this term was used by the government during the 1990s to focus attention on the problems that dependent drug users cause rather than on the problems they have. Their already hybrid status of ‘sick-but-deviant’ was thus reinforced.

The ‘multi-disciplinary’ approach referred to by the ACMD in their report Treatment and Rehabilitation has been translated to the partnership working of the drug treatment workforce and the criminal justice system. The partnership working of the drug treatment workforce and other health and social care agencies, however, has been neglected. Consequently, dependent drug users who have not accessed treatment via the criminal justice system receive a less intensive and, importantly, less refined service than their criminal justice counterparts.

Moreover, the apparent priority afforded to offending dependent drug users and the increasing alignment between drug treatment and the criminal justice system has isolated the drug treatment workforce from other health and social care agencies. Hence, those accessing treatment from outside the criminal justice system find it difficult to get problems relating to mental health and housing resolved. This group of dependent drug users are ‘truly the people nobody owns’. Firstly, they are not offending. Therefore, the social and economic costs they cause are relatively little in comparison to their offending counterparts. Secondly, their mental disorder is not sufficiently problematic that it causes risk to the public. Hence, they are not considered a priority group. Consequently, their problems remain unresolved.
Working relationships with health and social care services are often present on the basis of informal and past working relations. There exists, therefore, much inconsistency from worker to worker.

On a positive note, however, this chapter does show that despite the difficulties of multi-agency working it can be successfully implemented, and this has been shown in the alliance that has been created between the drug treatment workforce and the criminal justice system. To take multi-agency working to the level required to address the multiple needs presented by dependent drug users, however, drug policy needs to focus on the reintegration of the drug treatment workforce into local community health and social care services. Only when such integration is achieved can a fully multi-disciplinary approach to the treatment of drug dependency be realised.
Chapter 8: Discussion

“I had motives external to myself which he [the opium-eater] may unfortunately want: and these supplied me with conscientious supports which mere personal interests might fail to supply to a mind debilitated by opium” [Thomas De Quincy, 1821]

8.1. Introduction

The primary aim of the research presented in this thesis was to analyse the treatment journeys of dependent drug users, and in particular to identify and explain some of the key issues that determine access to drug treatment, other healthcare and social services necessary to meet the multiple and complex problems presented by dependent drug users. To achieve this aim, semi-structured interviews were conducted with dependent drug users, their key workers and a range of other professionals working in the drugs field.

The research identified a number of factors that may determine access to drug treatment, other healthcare and social services. Factors ranged from experiences of stigma, the motivation of the user to ‘get well’, and related to this, the extent to which they seek and cooperate with treatment, the apparent isolation of the drug treatment workforce, lack of information sharing and communication, and the differing treatment ideologies of key workers. These factors may be grouped and explained under two broad themes: the identity of dependent drug users and the changing role of drug workers, each of which, this thesis argues, has been impacted upon by the changes in, and focus of, drug policy.

The aim of this chapter is to turn back to the key themes and issues running throughout the core of this thesis. Firstly, this chapter summarises the theory or explanation provided for the continued neglect of the various treatment needs presented by dependent drug users. Secondly, based on the findings of the research, this chapter offers some recommendations for drug policy makers and commissioners. The drawbacks and limitations of the research
methodology are then acknowledged, followed by some concluding remarks regarding the future of drug policy and drug treatment.

8.2. Drug policy as a framework to explain the treatment journeys of dependent drug users

Developments in drug policy have attracted considerable research interest (Berridge, 1996a; 1996b Stimson, 2000; Yates, 2002; Mold, 2004; Duke, 2006; Reuter and Stevens, 2008). While insightful attempts have been made to explain these developments (Seddon, Ralphs and Williams, 2008; Seddon, 2010b), relatively little attention has been paid to the practical implementation and operation of current drug policies, particularly with regards to the treatment journeys of dependent drug users. This thesis attempts to address this deficit.

The policy response to drug addiction over the past 150 years has changed dramatically. There has been a substantial shift in the perception of drug use within society. The definitions applied to addiction began as a ‘bad habit’ for a minority, but soon became defined as a disease that was to be treated and subsequently ‘cured’, to what is now regarded as a ‘problem’, which is to be monitored, controlled and managed. A matter that fell within the jurisdiction of the medical practitioner soon became a matter to be also managed by the criminal justice system. In fact, at the time of writing, the criminal justice system had become a key player in the provision of drug treatment, particularly its potential to provide a pathway into drug treatment (Department of Health, 1996).

The medical and legal boundaries relating to the use of drugs and the activities surrounding it have become blurred. While addiction remains perceived and responded to as if it were a chronic disease to be treated by the medical practitioner, it often has legal consequences which must be addressed by the criminal justice system. The priority afforded to reducing ‘drug related crime’ has resulted in the creation of an alliance between the health care providers of drug treatment and the criminal justice system. As a result of the policy prioritisation of the drug-crime link and the emergence of DIP, an entirely new infrastructure has been constructed for drug interventions in the criminal justice system.
Drug testing teams and drug treatment workers now have permanent bases in custody suites up and down the country, with the latter also having permanent presence in magistrates’ courts, probation offices and prisons. It is not surprising then that several commentators contend that British drug policy has become crime focused (Stimson, 2000; Hunt and Stevens 2004; Duke, 2006; 2010; Stevens 2007; Seddon, Ralphs and Williams, 2008).

By the 1980s it became apparent that the medical model embraced by the DDUs, which had formed the cornerstone of heroin addiction treatment since 1968, was increasingly unable to respond to the varying needs of many individuals. As discussed in Chapter 2, it was around this time that there had been a massive transformation in the number and type of drug users. By 1985 the number of addicts notified had risen from 3425 in 1975 to over 14,688. The routes of administration had also changed. Heroin imported from Afghanistan and Pakistan was particularly well suited to smoking rather than injecting. In 1979 most heroin users first took the drug intravenously but by the end of the 1980s the majority of new users began taking the drug by inhalation (Griffiths, Gossop and Strang, 1994). Furthermore, heroin users were not only using heroin, they were often taking a range of other drugs by a variety of routes. Consequently, the ‘British system’ for drug treatment was, at this point, failing, and the ‘clinic’ system which was the focal point of the response to drug dependence in the UK, was considered inadequate (The Lancet, 1982). DDUs were under-resourced, under-staffed, and waiting lists had lengthened considerably, acting as disincentives to those seeking treatment. Moreover, those who did manage to be seen at the DDU often found that the treatment on offer did not suit them.

In an effort to shift the attention away from the failing narrow medical model of the DDUs towards a more multi-disciplinary approach, the ACMD (1982:34) introduced the concept ‘Problem Drug User’, defined as:

‘any person who experiences social, psychological, physical, or legal problems relating to intoxication and/or regular excessive consumption and/or dependence as a consequence of his own use of drugs or other chemical substances’.

This definition focused on the needs and problems of the individual and placed less emphasis on the drug orientated approach that had been common in previous years. It was a
holistic definition which acknowledged that the problem drug user had social, psychological, physical and legal needs. The definition of PDU provided during the 1990s and the drug policy that followed, however, focused on the social and economic costs associated with drug use, particularly with respect to the belief that much acquisitive crime was drug-related; in other words, was committed to finance drug use. Hence, the focus was no longer limited to the problems of drug users but on the potential harm they could cause to the wider community.

Rather than widening the approach used to treat dependent drug users, the policy focus on the harms caused by them further reinforced the medical model of addiction which has continued to dominate British drug treatment policy. Drugs and drug users posed potential problems that required governmental action, and medical practitioners became the most appropriate people through which this action could be delivered (Seddon, 2011:33). For example, methadone maintenance has become the most common treatment for opiate dependence in the UK (Stimson and Metrebian, 2003). About 65% of the treatment population receiving prescribing services are in methadone treatment (Millar, 2011; Bullock, 2011), equating to approximately 100,000 drug users if using the most recent statistics from the National Drug Treatment Monitoring System (Roxburgh, et al. 2011). While ‘the harm reduction approach within the UK appears to have had only modest success in reducing the breadth of drug-related harms’ (McKeganey, 2006:565), it has nevertheless appeared to be successful in reducing offending behaviour (Lind et al., 2005; Gossop, 2005; Millar et al., 2008). The crime focused approach taken by British drug policy and the level of success associated with methadone maintenance perhaps explains its continued use as a treatment for drug dependence. Reductions in levels of offending and numbers of offending drug users have become key priorities for local governments and drug treatment providers, demonstrated further by the need to achieve targets set against the National Indicator 38, which was to reduce drug-related offending (HM Government, 2007). An NTA representative succinctly highlighted this paradox suggesting that “drug treatment can be successful even if the patient gets worse”:

“unlike other areas of health intervention, drug treatment can be successful, even if the patient gets worse...So if I’m the Chief Executive of a Council and I’m watching, I don’t know, a million pounds of my money going into drug treatment, well what am I interested
in? I’m not an NHS professional, I’m interested in community safety and I’m interested in antisocial behaviour and all the rest of it. But I’m also going to be interested in crime reduction. So if my million pounds reduces crime by 50%, well that’s a good investment for me. So the crime reduction dividend on my investment is worth paying, it’s a good return. Whether anybody gets well or not or better or not is by and large irrelevant…the intervention can be successful and the investment will be repeated even if, you know, in theory, even if the patient gets worse…they’re still dying prematurely, they’re dying from chronic conditions, liver disease, emphysema from all the cigarettes that they smoke, etc, etc, obesity, type 2 diabetes. So it’s still a very, very poorly population but as long as they’re not committing a crime” [NTA rep, pg 8].

Outcomes relating to the mental health, accommodation, and the employment status of dependent drug users have not been subject to targets. It is perhaps of no surprise then that such treatment needs and problems of dependent drug users remain largely unresolved. Drug treatment is doing what is expected of it – it is meeting the expectations of its commissioners. It is not, however, meeting the expectations or, indeed, needs of its clients.

The aim of the ACMD to shift attention away from the medical model has never been fully realised. At the time of writing, dependent drug use is predominantly understood and managed through the discipline of medicine – through the use of a synthetic substitutes such as methadone – and the criminal justice system, who have formed a partnership to address drug dependence and the problems that dependent drug users cause to society. According to the findings presented in this thesis, however, it seems that a fully multi-disciplinary approach is yet to be fully implemented.

This thesis also contends that the ‘risk-based’ approach which has dominated drug policy and driven the treatment of drug dependence helps to explain the identity of the dependent drug user and the role of the drug treatment workforce. Seddon (2011:417) argues that “since the mid 1960s, the drug problem has been recast as a matter of risk factors – whether in relation to the metaphorical ‘socially infectious disease’, a real contagious disease (HIV), or criminal victimisation – which need to be monitored, controlled and managed”, and PDUs have been viewed as sources of those risk factors (Seddon, Ralphs and Williams, 2008). Therefore, due to its success in reducing offending behaviour (Lind et al., 2005; Gossop, 2005; Millar et al., 2008) the use of synthetic substitutes (particularly methadone)
has dominated the treatment of drug dependence. As a consequence of these policy directions, dependent drug users have been assigned to the ‘sick role’; the criteria for which they do not fulfil, impacting negatively on their identity. Moreover, this priority to break the so-called drugs-crime link has resulted in the creation of an alliance between the drug treatment workforce and the criminal justice system, which has not only isolated drug workers from other health and social care organisations but has had implications for their role and responsibilities.

8.2.1. On the identity of the dependent drug user

Despite the recommendations made by the ACMD in 1982 that were intended to shift attention towards a more multi-disciplinary approach, the narrow medical model of drug treatment has largely remained. Certainly, there has been substantial recognition that addiction is a bio psycho social problem (Marlett, et al. 1988; McMurran 1994; Griffiths, 2005), and the needs of dependent drug users extend beyond the physical and psychological into the social and environmental (ACMD, 1982). Yet, perhaps due to its success in reducing crime, it is the biological needs of dependent drug users (and more specifically, opiate users) that are often treated first and foremost:

“The problem of heroin addiction has been variously described in moral, social, psychological, legal and medical terms. The use of methadone involved a decision to define it as a medical problem and to focus on the most manageable and most easily understood of the problems of the addict – his physiological needs” (Nelken, 1973:4-5).

Needs relating to accessing and maintaining stable accommodation, gaining employment and resolving mental health problems, on the other hand, often remain unresolved. This narrow focus, this thesis has argued, has helped to reinforce and recreate the stigmatised identity of dependent drug users preventing them from accessing services they might require and ultimately determining progression through treatment.

The medical model that continues to dominate the treatment of drug dependence, perhaps because of its success in monitoring, controlling and managing the risk factors posed by PDUs, gives authority to the medical practitioner who “by virtue of being the authority on what illness ‘really’ is… creates the social possibilities for acting sick” (Friedson,
Dependent drug users, who are otherwise stigmatised, are provided with the opportunity to access a role – and remain within it – that potentially legitimises their otherwise deviant behaviour. Moreover, in the absence of resolving the psychosocial problems associated with drug dependency, the sick role potentially excuses them from fulfilling normal social obligations such as living in stable accommodation and maintaining employment. Chapter 6, however, demonstrates that efforts made by the drug user participants of this study to access the ‘sick role’, and remains within it produces an asymmetry between the ‘expressions they give’ and the ‘expressions they give off’. This asymmetry then discredits and throws doubt upon their projections about wanting to make changes to their current chaotic lifestyles, thus reinforcing their already stigmatised identity, preventing them from accessing the services they require and propelling them into continued drug-dependency.

The argument being put forward, therefore, is that the focus of drug policy on the harms caused by drug users has inevitably reinforced their stigmatised identity. However, before going any further the reciprocal nature of the relationship between drug policy and stigmatisation must be acknowledged.

The relationship between drug policy and stigmatisation appears to be causally interrelated. While this thesis demonstrates how drug policy might lead to stigmatisation the notion that stigmatisation might lead to the development of particular types of drug policy cannot be denied. As illustrated in Chapter 3, the change of direction in drug policy, from one that was concerned with the problems of drug users to one concerned with the potential harm they could cause to the wider community, was developed and implemented against a backdrop of media reporting emphasising the negative and stereotypical representations of illicit drug users (particularly heroin and crack cocaine users) as criminal outsiders and a threat to middle class sobriety. This imagery inevitably influences public opinion about drug users and the risks they pose (Blood, et al., 2003) leading to new policy making that gives the impression that the perceived threat is being addressed (Cohen, 1972). For example, the harm reduction measures implemented in the 1980s entered central government policy as a consequence of the ‘policy window’ created by the perception of AIDS as an emergency (Stevens, 2011: 83-84) rather than simply their effectiveness at
addressing drug-related harms. The extent to which policy causes stigma or stigma causes the development and implementation of new drug policy, therefore, remains in contention.

Nevertheless, it still stands that in order to break the cycle of stigmatisation, service providers need to distance themselves from the narrow model of drug dependence by providing dependent drug users with the means to *enable* recovery by focusing their treatment on mental health, housing, and employability rather than on drug dependency alone. In the absence of resolving these problems, addressing their addiction and becoming drug free becomes an unrealistic and often undesirable goal. Overcoming their addiction requires the dependent drug user to confront the negative social and psychological issues that can propel these individuals back into illicit drug use. Resolving these problems, therefore, should be made a priority. To reiterate the recommendations of the ACMD’s (1982) *Treatment and Rehabilitation* report, to *enable* recovery service providers need to confront and address the psycho-social problems which so often accompany drug dependence.

### 8.2.2. On the role of the drug worker

The drug policy focus to monitor, control and manage the risk factors posed by PDUs has helped to explain the role of the drug workers interviewed in this research. The focus of drug policy to break the so-called drugs-crime link and promote greater involvement of the criminal justice system in controlling problem drug use has forced what appears to be an unlikely marriage between health oriented agencies and criminal justice agencies. As with all marriages, there has been an element of compromise, which has impacted on the role and practice of the drug worker, and ultimately their working relationships with other health and social service providers.

The role of the drug worker is no longer confined to the achievement of therapeutic goals. The objective to divert drug using offenders from the criminal justice system into community drug treatment, while controversial (Stimson, 2000; Hough, 2002), has led to crime reduction being regarded as a key indicator of the success of drug treatment by policy makers, commissioners, and as shown in Chapter 7, the drug workers interviewed for this
research. The role of the drug worker has changed from one that is concerned with care, health and harm reduction to one that is focused on monitoring, control and management.

Changing priorities and responsibilities have not only served to confirm the alliance they have with the criminal justice system but have also helped to isolate them from other health and social care professionals. Knowledge of referral pathways of services providing treatment or support for mental health, housing, unemployment and finance was variable between the drug workers interviewed. Hence, those drug using participants accessing treatment from outside the criminal justice system often found it difficult to resolve such issues. Consequently, dependent drug users who have not accessed treatment via the criminal justice system tend to receive a less intensive and, importantly, less refined service than their criminal justice counterparts.

Services that may previously have been defined as ‘help’, such as drug treatment, are now wrapped up in notions of punishment; a situation that very few agencies would have formerly tolerated but have had to accommodate for financial survival. McSweeney and Hough (2006:121) suggest that the government’s vision to deliver a ‘mixed economy’ of providers is beset with difficulties, which are largely due to competitive tendering. The emphasis on value for money results in contracting out, which is characterised by ‘caution, greed and meanness’ (McSweeney and Hough, 2006:121). Therefore, agencies are having to look after their own interests to prove their worth rather than working in genuine partnership. In the context of drug dependency, drug treatment agencies have come to accept their role in reducing crime. This policy focus has, after all, resulted in a substantial investment in drug treatment worth about £1.2 billion per year (Morse, 2010:4).

The framework of current drug policies undoubtedly help to explain the treatment journeys of dependent drug users interviewed in this research in a number of ways. The focus of drug policy ‘on those users who impose the greatest burden to the rest of society’ (Seddon, 2011:339) has emphasised the legal and moral dimensions of dependent drug use. Certainly, from the medical perspective dependent drug users are labelled as ‘sick’. However, as this thesis has shown they are still regarded as ‘deviant’ and thus treated as such.
The practice of the drugs workforce has become constrained by a criminal justice framework that is both rigid and punitive and holds individuals responsible for their behaviours. Such a framework is in direct contrast to that used in medicine where individuals are assigned to the ‘sick’ role and are therefore not held wholly responsible for their behaviours. When entering drug treatment, dependent drug users are labelled ‘patients’. However, the treatment protocol of required assessment and appointments, inflexibility, drug testing, and sanctions for breach of treatment rules are more akin to the status of offender than medical patient. As Vigilant (2001) explains, individuals receiving drug treatment have never fully achieved their status as ‘patients’ because they are not treated as patients.

The institutional interests of drug treatment services in care, health and harm reduction and the necessity to develop a long-term therapeutic relationship based on empathy, trust and respect conflicts in an ideological way with concerns about public protection, safety, and punishment. Nevertheless, the drug treatment workforce is expected to deliver in all aspects. This tension between a milieu of engagement and empowerment and a milieu of distrust and control leave the dependent drug user caught between the status of a patient and offender, and drug treatment workers caught between their aspirations to reduce harm and duties to carry out regulatory-imposed policing functions.

8.3. Recommendations for drug policy and commissioning

The research presented in this thesis has identified some of the key factors that determine access to drug treatment, other healthcare and social services necessary to meet the multiple and complex problems presented by dependent drug users. To reiterate, these factors have ranged from: experiences of stigma; the perceived motivation of the user to ‘get well’, and the perceived extent to which they seek and cooperate with treatment; and the ineffectiveness of multi-agency working that has partly resulted from the apparent isolation of the drug treatment workforce, lack of information sharing and communication, and the differing treatment ideologies of key workers. Indeed, these factors have been identified by other research as impeding access to treatment and preventing recovery (Turnbull et al,
2000; Barton and Quinn, 2002; Hough et al., 2003), and a number of recommendations have been made by this research. However, the aim of this thesis has been to begin a dialogue that helps to explain the existence of such barriers; a dialogue that goes above and beyond it being about lack of knowledge and understanding among professionals and within society. Situating the factors identified here under two broad themes, namely the identity of dependent drug users and the changing role of drug workers, this thesis has been able to consider explanations relating to an overarching factor, being that of drug policy agenda. As a result, this thesis is able to offer recommendations that go beyond the often cited recommendations, such as simply increasing communication between services, and that may help to sustain recovery.

Before detailing these recommendations it seems necessary firstly to consider what the purposes of drug treatment should be. It has been shown in this thesis that drug treatment and drug workers are expected to deliver in aspects of care, health and harm reduction in respect of individuals. However, they are also expected to deliver in aspects of public protection, safety and punishment. It has been this dual, and in some ways conflicting, role that has created the problems identified in this research. Having a clearer, more coherent set of objectives, therefore, may be the first step in addressing some of these problems.

In *Putting Full Recovery First* (2012:2), Lord Henley, Chair of the Inter-Ministerial Group on Drugs, suggests that the government’s “goal is to enable individuals to become free from their dependence, to recover fully and live meaningful lives”. This goal is in line with the goal of the Drug Strategy (HM Government, 2010:) which “is to enable individuals to become free from their dependence; something we know is the aim of the vast majority of people entering drug treatment. Supporting people to live a drug-free life is at the heart of our recovery ambition”. Assisting individuals in their treatment with the overarching aim of becoming abstinent from all drugs, therefore, appears to be the goal of these policy directions.

While I generally agree with the sentiment of these messages there remains some concern over where the emphasis of drug dependency treatment will be placed as a consequence. The very title *Putting Full Recovery First* suggests an emphasis that does not resonate with
the findings of this thesis. It was argued in Chapter 6 that to enable recovery, or at least the desire to get ‘well’, service providers need to initially confront and address the psycho-social problems which so often accompany drug dependence. Addressing mental health problems, providing stable accommodation and the means to gain employment should be made priorities for treatment providers. Therefore, the emphasis is placed on the need to ensure that needs are met to *enable* dependent drug users to recover; the emphasis is not on the issues of full recovery, time limited treatment or an underlying goal of abstinence, for which, as Daddow (2012) quite rightly points out, “may alarm those in treatment who already fear the threat of time-limited sanctions”. I am somewhat cautious, therefore, about the messages put forward in *Putting Full Recovery First* and as a consequence of the findings of this research I believe firmly that to *enable* individuals to recover from drug dependency the notion of full recovery should not be put first at all.

The recommendations made here are not the type that can be implemented immediately. Rather, they will require investment, agreement and, importantly, time on the part of drug policy makers, commissioners, drug treatment providers and academic advisors.

### 8.3.1. Resolving the issue of identity

First of all this thesis makes a call for the redefining of drug treatment based initially on the redefining of the dependent drug user. It has long been recognised that dependent drug users often present to treatment with at least one other significant issue or problem, such as mental health, legal problems, inadequate housing, skill deficits, unemployment, inadequate or anti-social support networks, and financial issues. Yet, as illustrated by this research, they are often understood and consequently treated within a medical and criminal justice framework, labelled as both patient and offender. These frameworks are not only contradictory in their ideologies creating problems for the identity of the dependent drug user and the role of the drug treatment worker, but are failing to meet the multiple and complex needs of dependent drug users presenting to treatment. The problem to address initially, therefore, relates to language and the way in which individuals who use drugs are described.
Terms such as ‘dependency’ (with its close association with the DSM-IV definition) are clearly rooted in medical vocabulary and are likely to have reinforced the over-use of pharmacological interventions that exist at the time of writing. Dependency may well conform to the WHO criteria of disease but the ‘recovery debate’ appears to show a growing acceptance that the problems faced by clients presenting to services go beyond the neurological, psychological and biological and enter the realm of social and spiritual issues such as relationships and housing. Moreover, there appears to be a growing consensus in the belief that the balance between pharmacological interventions and more holistic approaches needs to be addressed. Therefore, the continued use of this term to describe a group of people who suffer from a variety of problems, drug dependency being only one of them, is problematic. Individuals should, therefore, be defined by their needs, not necessarily by only one of their many problems that further marginalises their status in society and reinforces stigmatisation.

Dependent drug users should not be solely defined by their drug dependency as this is only one of their many problems. These individuals are not only dependent on drugs but, as this thesis has shown, may also be homeless, jobless and suffering from mental disorders, none of which should be any less of a priority than their drug dependency. It is known, for example, that individuals are more likely to escape the cycle of dependency if they have stable accommodation and employment (Stevens, 2011: 145). Therefore, these individuals should be regarded as persons with life problems and should be defined, understood and treated on this basis. This thesis suggests that taking the emphasis off their drug dependency will help to destigmatise their addict identity, which can act as a barrier to services they require and ultimately recovery from their dependency.

8.3.2 Reconciling the role of the drug worker

Once the issue of identity has been resolved and dependent drug users are at last recognised as persons with life problems, of which one is drug dependency, thinking about the commissioning of services can begin.
Along with poverty, homelessness, unemployment and, for some, mental health, drug dependence is a problem of life, it “is not a progressive, lifelong medical condition, as many experts contend, but a negative pattern of behaviour – a ‘problem of life’ that often resolves itself organically” (Peele, 2011). To address the ‘problems of life’ then surely requires input from numerous agencies and/or expertise.

Building upon this premise, it is perhaps sensible to suggest that multi-agency working is necessary to address the multiple and complex problems presented by dependent drug users and should be regarded as a central feature of a drug worker’s role. However, the findings presented in this thesis have already identified the problems of this approach. Multi-agency working has yet to be effectively implemented and where attempts have been made such working practices remain varied and inconsistent. The apparent priority afforded to offending dependent drug users and the increasing alignment between drug treatment and the criminal justice system has isolated the drug treatment workforce from other health and social care agencies. Therefore, before entering into discussions about how to reintegrate dependent drug users into local communities (NTA, 2010), policy makers and advisors should be initially thinking about ways in which the drug treatment workforce can be reintegrated in local community health and social care services to enable effective referral and collaboration for issues such as mental health, housing and education. The document *Putting Full Recovery First* (HM Government, 2012:18) emphasises that “full recovery can only be achieved through working with education, training, employment, housing, family support services, wider health services and, where relevant, prison, probation and youth services, to rebuild a person’s life”. In the following paragraph, however, it suggests that the government “will encourage local areas to jointly commission recovery services so they deliver ‘end-to-end’ support for individuals, and ensure a seamless transition between providers – particularly for those adults moving between the criminal justice system and community services”, again placing emphasis on the development of effective relationships between the criminal justice system and the drug treatment workforce.

On a positive note, this thesis has shown that despite the difficulties of multi-agency working, it can be implemented successfully; some success has manifested, ironically, in the alliance created between the drug treatment workforce and the criminal justice system.
To take multi-agency working to the level required to address the multiple needs presented by dependent drug users, however, drug policy and commissioners need to focus on the reintegration of the drug treatment workforce into local community health and social care services. Only when such integration is achieved can a fully multi-disciplinary approach to the treatment of drug dependency be realised.

The input from multiple agencies might not be necessary to address the multiple and complex problems of dependent drug users but what is necessary is the use of multiple disciplines, which may be delivered by one service or in the same building. This suggestion is certainly consistent with messages communicated by government Ministers. For example, according to then Health Secretary, Andrew Lansley (2011), multi-disciplinary working is “at the heart of designing services better”. Moreover, the notion of a more holistic, one-stop shop is supported by many service users (Eley et al, 2005). As with the findings presented here the participants of Eley et al’s (2005) study argued that “if there was tangible support available for the social and economic realities of their lives, then getting off drugs and living a drug-free life could be an attainable goal” (2005:408). Consistent with this viewpoint were the findings of Stevens et al (2008) who suggested that people are more likely to engage in drug treatment if they are offered services which they do not experience as stigmatising, that are provided to them at convenient times and locations and, importantly, that address their full range of needs. As Stevens (2011:145) points out ‘such services might be better in the context of mainstream health services than in specialist drug treatment settings’. In a similar vein, it is the suggestion of this thesis that drug workers should be reinvented as old-style generic social workers who address individuals holistically and who are “trained, able to understand, and appropriately respond to, a wide range of individual needs” (Baker, 1975:193), with a strong pragmatic focus on ‘getting things done’ in relation to issues such as housing and unemployment.

Provision within the drug treatment services recruited to this study, however, did not fit into these models and could not practically offer help such as debt counselling, assistance with accommodation and benefits, parenting classes and crèches – arguably provisions that could be supported by partnership arrangements. Although the drug workers interviewed were trained in psychosocial interventions in accordance with NTA’s Models of Care their
time was often taken up by regulatory policing activities such as monitoring attendance or dispensing prescriptions. A change of focus is required, therefore, away from the ‘risk-based’ approach that has dominated drug policy, driven the treatment of drug dependence, and made ‘knowledge work’ (Seddon, Williams and Ralphs, 2012) the core of activity for drug workers, towards an approach that is focused on meeting the various and complex needs of people with life problems. This may be an approach that encourages, rather than develops relationships that discourage, the integration of drug workers into other health and social care services. Alternatively, as suggested above, it could be an approach that reinvents drug workers as old-style generic social workers reminiscent with an approach that focuses on ‘getting things done’ in relation to issues such as housing and unemployment.

8.4. Limitations

Before turning to the conclusions, this study must reflect upon its drawbacks and limitations.

Firstly, this research was a relatively small scale, localised study with an opportunistically recruited group of dependent drug users. Owing to the complex nature of drug dependency and its treatment, it would have been virtually impossible to examine every possible permutation of the treatment journeys of dependent drug users and the barriers they confront when accessing services they might require. The study focused specifically on drug users attending prescribing services for their drug dependency problems. It does not account, therefore, for the views of drug users not attending treatment or attending other types of drug treatment services such as, for example, narcotics anonymous. Consequently, the findings presented in this thesis are mainly relevant to those dependent drug users who remain in maintenance treatment for many years, and are considered by many to be ‘stuck’ in treatment (Madden, et al., 2008). The findings might not be relevant to the wider population of drug users or those drug users in receipt of other types of drug treatment.
Secondly, the study selected its sample from only two DAT areas. While every effort was made to select areas that were diverse in terms of their urbanity, only two variants were allowed: an inner city area and a town. Had this been a study with little time restrictions a rural area would have also been chosen.

Thirdly, the longitudinal approach used in this study resulted in some attrition of dependent drug users between their first and second interviews. As noted previously only 10 of the original 16 were interviewed a second time indicating a 63 per cent follow-up rate. While there is some concern that this attrition may have led to a bias in the findings presented Hanston et al (2000) do suggest that it falls within the retention rate necessary to achieve meaningful analysis. Moreover, it must be acknowledged that the research presented in this thesis is a wholly qualitative one and is not concerned with presenting findings that are generalisable to the wider population. Furthermore, the acknowledgement of the findings’ relevance to those considered to be ‘stuck’ in treatment (Madden, et al., 2008) negate concerns of attrition since it were these participants that were relatively easy to follow-up and are therefore represented in the sample ultimately captured.

Some reflection must also be made of the method of data collection. Much of the data presented in this thesis was generated from interviews with service users and drug treatment practitioners. It is also important to note that one of the key findings to have been generated from this research relates to the stigmatisation of dependent drug users. It cannot be ignored, therefore, that such stigmatisation may have led to the concealment of information offered by the participants, thinking that there is stigma attached to the ‘truth’. It is not unusual, for example, for research participants ‘to lie or elaborate on the ‘true’ situation to enhance their esteem and/or to cover up discreditable actions’ (Fielding and Thomas, 2001:139). The very idea that research participants are concealing the truth is particularly problematic for positivists, whose view of society operates according to a series of laws like in the physical world, as it challenges the validity of the findings. It should be emphasised, however, that this study was not about the search of an ‘objective reality’ or ‘truth’ as positivist researchers might be inclined towards. Instead, this study was interested in the way in which experiences are told and thus interpreted. The explanations that have been presented in this thesis, relating to why an individual’s treatment journey may take
particular direction, therefore, may be regarded as one explanation of many. Hence, this thesis offers a theory as to why a dependent drug user’s treatment journey takes on a particular direction and why there exists certain barriers along the way; it does not pretend to be an all-encompassing theory or explanation.

While no claims to wider representativeness can be made, the accounts provided by the participants in this study cannot simply be dismissed as unreliable and idiosyncratic. Rather, they provide an insight into the experiences, views and preferences of dependent drug users and their treatment journeys.

8.5. Conclusion

Not only has this thesis demonstrated how the ‘risk-based’ approach to drug policy and drug treatment has placed emphasis on the medical and legal aspects of drug taking but has also illustrated how such an approach manifests in the practical operation of drug treatment, particularly with regards to the treatment journeys of dependent drug users and ultimately their chances of recovery. It has emphasised the multiple and complex problems presented by dependent drug users and has shown how such problems often remain unresolved. This thesis further contends that a drug policy that focuses on regulation and control helps to explain why dependent drug users have become stigmatised, not only by others but also by themselves, an identity which is reinforced and recreated by the medical model of addiction that is used widely in the UK, not only because ‘drug addiction’ has been described as a chronic and relapsing condition (NTA, 2002), but also because of the wider social control objectives (crime-reduction, in particular) that this approach delivers. Furthermore, the focus of drug policy to reduce crime has created what appears to be an unlikely partnership between the criminal justice system and the drug treatment workforce, isolating them from other health and social services. The negative identity attributed to dependent drug users and the isolation of the drug treatment workforce, this thesis contends, obstructs access to services that address issues relating to mental health, housing and employment. Such problems, therefore, often remain unresolved.
The ‘risk-based’ approach that has dominated drug policy and driven the treatment of drug dependence has framed drug dependence as both a medical and legal problem. The fact that upon presentation to treatment the majority of dependent drug users are prescribed with synthetic substitutes, such as methadone, suggests that drug dependence is a medical problem. Drug dependency is also, of course, framed as a legal problem. As with much social policy, the ‘drugs problem’ has been reclassified in relation to its crime control potential (Crawford, 1997, 1998; Blagg, Pearson, Sampson, Smith, and Stubbs, 1988). The overriding goal of much drug policy and practice has become crime reduction by getting offenders ‘out of crime and into treatment’. This is based on the premise that much acquisitive crime is drug-related, for example, is committed to finance drug use. In other words, if the drugs problems can be treated the crime problem will be solved. The medical model, which has been described as too narrow to address the multiple and complex problems presented by dependent drug users, has been reinforced, therefore, not only because ‘drug addiction’ has been described as a chronic and relapsing condition (NTA, 2002), but also because of the wider social control objectives (crime-reduction, in particular) that this approach delivers (Lind et al., 2005; Gossop, 2005; Millar et al., 2008). Therefore, issues ‘such as homelessness, poverty, unemployment and drugs are prioritised on the policy agenda because they are seen to cause crime and disorder, rather than as important public issues in themselves’ (Duke, 2006:413).

To fully enable recovery from drug dependence, therefore, current understanding and treatment of drug dependence needs to shift. During the last half of the twentieth century the boundaries between the ‘drug problem’ and the ‘crime problem’ have become blurred, and the social structural factors such as unemployment, poverty, and deprivation that are associated with both drugs and crime have been ignored. Issues such as homelessness, poverty, unemployment, and additional health related needs such as mental disorder, need to be prioritised, not on the basis that if resolved there will be a marked decrease in crime rates, but because these are important public issues in themselves and have been acknowledged as the drivers of drug dependency (Clinard, 1964; Hirschi, 1969; Harris and Edlund, 2005).
During the past 150 years of drug policy and treatment we have witnessed a behaviour which was once regarded as a ‘bad habit’ for a minority become medicalised and constructed as a disease requiring treatment and subsequently cure. This process gained speed during the second half of the twentieth century and drug dependency is regarded, at the time of writing, as a chronic relapsing disease (by organisations such as the NTA, Royal Pharmaceutical Society; Royal College of General Practitioners; The World Health Organisation); a definition which of course legitimises the use of synthetic substitutes which are effective at helping to reduce the offending behaviour. Alongside this ‘medicalisation’ of drug use, however, has been legislation designed and implemented to regulate, control and ultimately prevent the non-medical use of certain drugs resulting in what some have termed the criminalisation of drug policy (Stimson, 2000; Duke, 2006; Seddon, Ralphs and Williams, 2008). Dominant thinking in relation to problem drug use emphasises the medical related aspects of problem drug use and the legal aspects in terms of criminal activity and the trouble caused to communities. Absent from current drug policy is the social context of problem drug use which is arguably the most important component (Buchanan, 2009). This thesis has shown that efforts to help people become drug free have often failed to address the entrenched underlying social and personal needs and the considerable difficulties overcoming stigmatisation. Unless such social aspects of problem drug use are tackled, relapse becomes almost inevitable. Shifting from the medicalisation and subsequent criminalisation of drug policy, it is perhaps time for drug policy to become socialised, refocusing on the problems that dependent drug users have rather than the problems they cause or the ‘risks’ they pose.
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Appendices
Appendix A: Service user consent form to be interviewed

CONSENT FORM 1: Service Users

Researcher: Ask the participant to read the service user leaflet and answer any questions. If the participant agrees to be interviewed, ask them to read and sign their consent. If the respondent is unable to read, please read out the consent form to them.

Consent to be interviewed: Please initial box

1. I confirm that I have read/had read to me the information sheet dated 01/02/07 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, and without my treatment status, medical care or legal rights being affected.

3. I understand that my interview will be recorded and written out word for word. The recording and interview notes containing my answers will be securely stored in accordance with the Data Protection Act and later destroyed.

4. I understand that anything I say will be treated in the strictest confidence, in accordance with the Data Protection Act. My answers will only be used for research purposes. The only potential breach to my confidentiality may be if I talk about a suicidal intent, or a risk of harm to somebody who can be identified, and who is not able to speak for themselves.

5. I understand that the research may use direct quotes from my answers. However, my identity will be kept anonymous at all times.

6. I agree to take part in the study by being interviewed

Name of participant Date Signature

Name of Researcher Date Signature
Appendix B: Service user consent form to examine case notes

Consent for Information Collection: Service Users

- Thank you for taking part in the Treatment Pathways interview.
- With your permission, I would like to find out more about your treatment from looking at your case notes.
- I would also like to talk to those individuals who you have identified has having an impact on the treatment you have received.
- Any information that I collect will be confidential and used for research purposes only.
- Names and addresses will never be included in the results and no individual will be identified from the research.
- You can cancel this permission at any time in the future by calling me on the following number: 0161 275 1658.

A. I __________________________ (name)

Consent for the researcher to collect information from my case notes in relation to my current treatment at this agency.

- I understand that the information obtained will be limited to the purposes of this study.
- My case notes can only be accessed by the researcher who has gained this consent.
- My consent will remain valid until withdrawn by me, which can be done at any time, without giving any reason, and without my treatment status or legal rights being affected.

Signed ___________________________ Date __________________________

Witnessed ___________________________
B. I _________________________ (name)

Consent for the researcher to discuss my case and circumstances with workers who have been involved with my treatment and who I have identified beforehand.

- I understand that the information obtained will be limited to the purposes of this study.
- My case and circumstances can only be discussed by the researcher who has gained this consent.
- My consent will remain valid until withdrawn by me, which can be done at any time, without giving any reason, and without my treatment status or legal rights being affected.

Signed ______________________    Date ______________________

Witnessed ______________________

C. I _________________________ (name)

Consent for the researcher to discuss my case and circumstances with other individuals who I have identified as having an impact on my treatment (these may include family members, friends and other acquaintances)

- I understand that the information obtained will be limited to the purposes of this study.
- My case and circumstances can only be discussed by the researcher who has gained this consent.
- My consent will remain valid until withdrawn by me, which can be done at any time, without giving any reason, and without my treatment status or legal rights being affected.

Signed ______________________    Date ______________________

Witnessed ______________________

1 copy for participant, 1 copy for researcher
Appendix C: Service user contact sheet

**CLIENT DETAILS SHEET**

Please complete for those clients who you have agreed to be interviewed

**TO THE CLIENT:** To help me get in touch, please fill in as much contact information as you can.

**All items are OPTIONAL**, but I would appreciate a name and a phone number as a minimum.

<table>
<thead>
<tr>
<th>CONTACT DETAILS:</th>
<th>Home Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forename</td>
<td>Surname</td>
</tr>
<tr>
<td>Telephone number</td>
<td></td>
</tr>
<tr>
<td>Mobile number</td>
<td>Postcode:</td>
</tr>
</tbody>
</table>

Please give **any other information** that might help us to get in touch with you (the client) in case you move or change phone number. **All information is optional and confidential.** We will only use this to get in touch with you about the study, we won’t use it for any other reason.
CONSENT FOR AGENCY TO PASS ON CONTACT DETAILS TO RESEARCHER:

<table>
<thead>
<tr>
<th>I _______________________________ (name of client)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Agree that Samantha Weston from the University of Manchester can contact me in the next few weeks using the details above.</td>
</tr>
<tr>
<td>• I understand that Samantha will explain the research project to me, and ask me if I want to take part. I do not have to decide now whether to take part or not.</td>
</tr>
<tr>
<td>Signed ______________________________ (client)</td>
</tr>
<tr>
<td>Witnessed ____________________________ (agency worker) Date: / /</td>
</tr>
</tbody>
</table>

Samantha Weston will contact you soon to talk about the study.

If you have any questions in the mean time, please call Samantha Weston on 0161 275 1658 or email Samantha.k.weston@manchester.ac.uk
Appendix D: Service user first interview topic guide

Service Users Interview
Topic guide

As this is an exploratory study, participants will be encouraged to discuss their views and experiences in an open way without excluding issues which may be of importance to individual respondents and the study as a whole. Therefore, unlike a survey questionnaire or semi-structured interview, the questioning will be responsive to respondents’ own experiences, attitudes and circumstances.

The following guide does not contain pre-set questions but rather lists the key themes and sub-themes to be explored with each group of respondents. It does not include follow-up questions like ‘why’, ‘when’, ‘how’, etc. as it is assumed that respondents’ contributions will be fully explored throughout in order to understand how and why views, behaviours and experiences have arisen. The order in which issues are addressed and the amount of time spent on different themes will vary between individuals and according to individual demographics and dynamics.

1. **Introduction**
   *Aim: To introduce the research*
   
   - Introduce self
   - Introduce research
   - Explain: confidentiality, recording of interview (re-confirm consent when the recorder is running), length (about an hour) 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
  - 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
  - Age of first use
  - How did you start
    Probe for general background information
  - Age of first problematic use
  - Amount and frequency since first use
    Probe for use of drug in the last month
- Use alone or with others (who)
- Motivation for use
  Probe for peer or family influence
- How pay for drugs
- How important is access to a supply of drugs
  - Compare to other essential 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. **Mental Health**

*Aim: To examine the extent of mental health history*

- Ever been referred to a psychiatrist/psychologist or any other mental health worker? *Probe for details*
- Ever been diagnosed with a psychiatric/mental health condition? *Probe for details*
- Ever received treatment or help for a psychiatric/mental health need? *Probe for details*

5. **Offending activity**

*Aim: To examine the type and level of offending and participant attitudes.*

- Ever offended
  - Type of offences committed
  - Reasons for offending
  - Age of first offence
  - How did you start offending
  - Amount of frequency of offending activity
- Offend with others or alone
- What help have you received to prevent you from offending? (*have you ever received interventions from the probation service/YOTs/prolific offender schemes/criminal justice workers?*)

Invite the participant to think about his or her own perception of their offending activity

- What impact does offending have on their life
- Family/friends knowledge of offending – do they also offend

6. **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 – if necessary, introduce a timeline

- Age of first drug treatment experience
- Motivation to seek drug treatment
- Referral route
- What treatment was received
  - Length of treatment
Perception of staff
- Attendance (if poor attendance, probe for reasons)
- Receive treatment/advice for mental health problems?
- Receive treatment/advice for offending problems?
- Reason for treatment ending (Probe for details, i.e. were reasons to do with any of the following: family, peer, community influences, adequacy of treatment received…)
- General impression of intervention

Personal outcome
- Long-term change / short-term change / no change
- Management / stabilised use
- Other outcomes (mental health/criminal issues etc)
- If became abstinent – Length of time before started to use drugs again

If participant has had more than one previous treatment experience, ask above questions for each experience.

7. **Current treatment**

*Aim: To explore the participant’s journey into the current their treatment episode*

- Referral route - When / why / by whom

**Pre-treatment attitudes**

In the course of the discussion, probe for the following in relation to drug treatment, mental health treatment and help received for offending behaviour:

- 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)
  - Agency staff / Family / friendships
  - Stop offending / remain out of custody
- Who helped you get into treatment this time? (agency staff, family, friends)
- Support received for family/friends etc
- Family view of treatment
- Friends view of treatment
- Where do you want to be in twelve months
  - Goals (i.e. abstinence etc)
Current drug treatment experience

Ask the participant to talk about the treatment they are currently receiving. Probe for:

- What type of drug treatment receiving now?
- What do you have to do, how many times do you have to attend?
- How does it work
- Care plan details
- Who delivers it
  - Perception of staff delivering
  - Is there a particular person in charge of your care that you can always discuss issues with or that has influenced the treatment you are receiving in any way? If yes, how?
- Anticipated outcome
  - Cessation of use or other issues (*improved self-efficacy etc*)

Current mental health treatment experience

- Currently receiving treatment for mental health problems?
- What treatment?
- By whom?
  - Perception of staff delivering
  - Is there a particular person in charge of your care that you can always discuss issues with or that has influenced the treatment you are receiving in any way? If yes, how?
- What do you have to do?
- How does it work in relation to other treatment you are receiving?
- Anticipated outcome

Current treatment experience for offending problems and other drug related problems

- How is treatment helping with your offending/legal problems?
- Are you receiving any help/advice from a probation worker/YOT worker/ prolific offender scheme/criminal justice workers? If so, how does this work with other treatment you are received? Probe for details re agency collaboration etc.
  - Perception of staff helping you with your offending behaviour
  - What do you have to do?
  - How does it work in relation to other treatment you are receiving?
  - Anticipated outcome
**Relationships with service providers and significant others** *(ask in relation to all treatment received – drug/mental health/offending behaviour)*

- Views of service providers
  - Experiences *(positive vs. negative)*
  - Compare / contrast with providers from previous treatment
  - Does anyone have overall management of your treatment – that is, treatment for your drug/mental health/offending problems? If yes, who? What do they do?
- Key people involved in your treatment? *(do not restrict to service providers, could be family members, friends etc)*
  - Who?
  - What do they do?

**Overall view of current treatment**
- Compare / contrast with any previous treatment episodes
  - Individual needs met
- Whether they will complete
  - Influences that may affect this
Appendix E: Service user follow-up interview topic guide

Service Users Interview – Follow-up
Topic guide

As this is an exploratory study, participants will be encouraged to discuss their views and experiences in an open way without excluding issues which may be of importance to individual respondents and the study as a whole. Therefore, unlike a survey questionnaire or semi-structured interview, the questioning will be responsive to respondents' own experiences, attitudes and circumstances.

The following guide does not contain pre-set questions but rather lists the key themes and sub-themes to be explored with each group of respondents. It does not include follow-up questions like `why', `when', `how', etc. as it is assumed that respondents' contributions will be fully explored throughout in order to understand how and why views, behaviours and experiences have arisen. The order in which issues are addressed and the amount of time spent on different themes will vary between individuals and according to individual demographics and dynamics.

1. **Introduction**

   *Aim: To introduce purpose of follow-up interview*

   - Introduce purpose of follow-up interview – to find out what has happened since the previous interview
   - Explain: confidentiality, recording of interview (re-confirm consent when the recorder is running), length (about an hour) and nature of discussion (specific topics to address, but conversational in style), reporting and data storage issues
   - Any questions?

2. **Present circumstances**

   *Aim: To examine the extent to which the participant’s life and wider social networks have changed since previous interview.*

   - Current housing
     - Where living
- How long lived there
  - Live alone / with others
- If accommodation status different from information provided in the initial interview, ask about what prompted changes
  - Help from services
  - Self help
- Main daytime activity
  - Full-time employment
  - Part-time employment
  - Voluntary work
  - Further education / Govt. training scheme
  - Unemployed
- If daytime activities different from information provided in the initial interview, ask about what prompted changes
  - Help from services
  - Self help
- Relationship status
- Finances
  - View of current financial status
  - Difficulties / debt
- If financial status different from information provided in the initial interview, ask about what prompted changes
  - Help from services
  - Self help
- Health
  - General perception
  - Any difficulties
    
    *Only probe if major illness is disclosed – if disclosure is made, use discretion regarding level of detail explored.*
  - Any improvements or deterioration in physical health since last interview

3. **Drug use profile**

   *Aim: To examine the type and level of drug use at follow-up interview.*

   - Types of drugs using at the moment, if any
     - Amount and frequency of use since last interview
       
       *Probe for use of drug in the last month*
   - Motivation for use
       
       *Probe for peer or family influence*
   - How pay for drugs
   - How important is access to a supply of drugs
     - Compare to other essential such as food, clothes, music etc
• Perception of current drug use and how this compares with 6 months ago (last interview)

4. **Drug treatment experiences**

*Aim: To explore in detail the participant’s experience of drug treatment since their last interview.*

Ask the participant if they are still in the same treatment episode they were in at last interview:

If yes, ask for a recap of information collected at first interview in terms of:
- Referral route - When / why / by whom
- Pre-treatment attitudes
  - 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)
    - Agency staff / Family / friendships
    - Stop offending / remain out of custody
  - Who helped you get into treatment this time? (agency staff, family, friends)
  - Support received for family/friends etc
  - Where do you want to be in twelve months
    - Goals (i.e. abstinence etc)

Ask the participant to talk about the treatment they are currently receiving. Probe for:

- What type of drug treatment receiving now?
- What do you have to do, how many times do you have to attend?
- How does it work
- Care plan details
  - Plans to access other services?
- Who delivers it
  - Perception of staff delivering
  - Is there a particular person in charge of your care that you can always discuss issues with or that has influenced the treatment you are receiving in any way? If yes, how?
- Any changes since last interview in terms of:
  - Key worker/drug worker/probation officer changes
  - Relationship with GP
- Anticipated outcome
o Cessation of use or other issues (*improved self-efficacy etc*), and how this compares with last interview

Ask the participant to talk about any new drug treatment which they have commenced since last interview (refer to date of interview)

- Prompt for information and progress about appointments which were planned at last interview

Ask the participant to talk about treatment which they have completed or which has ended for any other reason since last interview.

- If completed treatment, what aftercare have they received?
- If dropped out of treatment
  - What factors prompted you to drop out
  - What factors would have influenced you to stay in treatment

5. **Mental Health Problems and Treatment**

*Aim: To examine the extent of mental health problems since last interview*

Ask the participant to provide a recap of their current mental health problems

- Changes in status
  - Have mental health problems become more difficult, improved
  - If mental health problems have changed, prompt for reason for change

Since last interview have you:

- Been referred to a psychiatrist/psychologist or any other mental health worker? *Probe for details*
- Been diagnosed with a psychiatric/mental health condition? *Probe for details*
- Received treatment or help for a psychiatric/mental health need? *Probe for details*
  - Have you commenced any new treatment since last interview
  - What treatment?
  - By whom?
    - Perception of staff delivering
    - Is there a particular person in charge of your care that you can always discuss issues with or that has influenced the treatment you are receiving in any way? If yes, how?
  - What do you have to do?
  - How does it work in relation to other treatment you are receiving?
  - Anticipated outcome

Ask the participant to talk about treatment which they have completed or which has ended for any other reason since last interview.

6. **Offending Problems and Services Accessed**
Aim: To examine the type and level of offending since last interview.

Since last interview have you:

- Offended at all?
  - Type of offences committed
  - Reasons for offending
  - Amount of frequency of offending activity
- Been to prison as a result of your offending?
  - Treatment received in prison – prompt for detail
- Received any further help to prevent you from offending? (have you received interventions from the probation service/YOTs/prolific offender schemes/criminal justice workers?)
  - How is treatment helping with your offending/legal problems?
  - Are you receiving any help/advice from a probation worker/YOT worker/prolific offender scheme/criminal justice workers? If so, how does this work with other treatment you are received? Probe for details re agency collaboration etc.
    - Perception of staff helping you with your offending behaviour
    - What do you have to do?
    - How does it work in relation to other treatment you are receiving?
    - Anticipated outcome

7. **Other services**
To examine the level of access to other services (housing, education, training, employment etc) since last interview

- What other services have you accessed since last interview
- Perception of services

8. **Relationships with service providers and significant others** (ask in relation to all treatment received – drug/mental health/offending behaviour)

- Views of service providers
  - Experiences (positive vs. negative)
  - Compare / contrast with providers from previous treatment
  - Does anyone have overall management of your treatment – that is, treatment for your drug/mental health/offending problems? If yes, who? What do they do?
- Key people involved in your treatment? (do not restrict to service providers, could be family members, friends etc)
  - Who?
  - What do they do?
- Level of communication between services
  - For example, If NACRO or similar services are involved, how, if at all, do these communicate with your other workers (drug/probation etc)
9. **Overall view of current treatment** *(ask in relation to all treatment received – drug/mental health/offending behaviour)*

- Compare / contrast with any previous treatment episodes
  - Individual needs met
  - Do you have any unmet need
- Whether they will complete
  - Influences that may affect this
  - What do you need to become abstinent
  - Do you think that the current service provision can maintain abstinence
- How, if at all, has your life improved since last interview
- How is life different now compared with 12 months ago?
  - What have been the factors that have got you where you are today?
Appendix F: Key worker and other professional consent form

CONSENT FORM: Service Providers

**Researcher**: Ask the participant to read the service providers leaflet and answer any questions. If the participant agrees to be interviewed, ask them to read and sign their consent. If the respondent is unable to read, please read out the consent form to them.

**Consent to be interviewed**: 

1. I confirm that I have read/had read to me the information sheet dated 01/02/07 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, and without my employment status or legal rights being affected.
3. I understand that my interview will be recorded and written out word for word. The recording and interview notes containing my answers will be securely stored in accordance with the Data Protection Act and later destroyed.
4. I understand that anything I say will be treated in the strictest confidence, in accordance with the Data Protection Act. My answers will only be used for research purposes. The only potential breach to my confidentiality may be if I talk about a suicidal intent, or a risk of harm to somebody who can be identified, and who is not able to speak for themselves.
5. I understand that the research may use direct quotes from my answers. However, my identity will be kept anonymous at all times.
6. I agree to take part in the study by being interviewed.

Name of participant

Date

Signature

Name of Researcher

Date

Signature
Appendix G Key worker interview topic guide

Keyworkers Interview
Topic guide

As this is an exploratory study, participants will be encouraged to discuss their views and experiences in an open way without excluding issues which may be of importance to individual respondents and the study as a whole. Therefore, unlike a survey questionnaire or semi-structured interview, the questioning will be responsive to respondents’ own experiences, attitudes and circumstances.

The following guide does not contain pre-set questions but rather lists the key themes and sub-themes to be explored with each group of respondents. It does not include follow-up questions like ‘why’, ‘when’, ‘how’, etc. as it is assumed that respondents’ contributions will be fully explored throughout in order to understand how and why views, behaviours and experiences have arisen. The order in which issues are addressed and the amount of time spent on different themes will vary between individuals and according to individual demographics and dynamics.

SECTION 1: GENERIC QUESTIONS (to be asked of all service provider representatives recruited in the study)

1. **Introduction**
   *Aim: To introduce the research*
   
   - Introduce self
   - Introduce research
   - Explain: confidentiality, recording of interview (re-confirm consent when the recorder is running), length (about an hour) 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 i.e. previous experience etc
• Description of agency
  o Intervention type?
  o Length of intervention?
  o Who delivers the treatment?
  o Staff continuity throughout the different treatment components?
  o Is there one person dedicated to organise the care of an individual? Who has the ultimate responsibility of co-ordinating an individual’s care? Is this left to the individual themselves or does someone organise it for them? Is this the same for those who have multiple co-existing problems (i.e. drug/mental health/offending problems)? If not, how does it differ?
  o Relative contribution of each component to the overall treatment pathway / programme?

• Roles and responsibilities within the treatment centre (support / mentoring / clinical supervision)
• Level of personal contact with clients
• Training and education for this role

3. Social / local context of treatment
Aim: To place the treatment programme and the client base into local context.

• In [DAT] area:
  o Who provides treatment for drug use?
  o Who provides treatment for mental health?
  o Who helps people with their offending problems?
  o Who provides help for people with other problems relating to their drug use, such as housing, employment, social/peer support, financial difficulties, general health?
  o Who provides treatment for those people with multiple co-existing problems? Is it provided by the same treatment provider, for example a dual diagnosis worker? If so, how does this work?

• Relationship with other/external agencies
  o E.g. for a drug treatment agency – what is their relationship like with mental health services, police, probation service, prison service, court service (formal vs. informal)

• What service do you provide for people with drug/mental health/offending problems?
• How does the service provision differ for those individuals with multiple co-existing needs compared to those with single needs? Are clients with multiple co-existing needs generally more difficult to treat than clients without such needs? If so, why do you think this is?

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 within the DAT to treat drug users with Multiple Co-existing Problems (and their view of how it should work within a DAT). Examples of other agencies may include drug treatment agencies, mental health providers or the Police / Prison / Probation Services.

- The extent and range of relationships between the interviewee (and their agency) with other agencies. 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)
  - Perceived effectiveness of relationship
- Process for developing and maintaining effective inter-agency working
  - Formal policy – are services integrated or do you still feel separated from other services?
  - Barrier / facilitators to effective working
- Perceived impact of inter-agency working
  - Impact on colleagues
  - Impact on clients
  - Overall impact on outcome
  - Advantages/disadvantages?
- Training

5. **Identification of Multiple Co-existing Problems (MCP)**
   *(Define what is meant by MCP)*

- How do you usually go about identifying clients with multiple co-existing problems?
- What are the criteria for treatment priority within your service (need to expand – i.e. mental health severity, drug use severity…)?

- Experience of drug use other than in a professional capacity? If yes, in what capacity?
- Understanding of drug use? What does it mean to you? Please indicate the sort of behaviour or symptoms a person would have that would indicate a drug problem

- Experience of mental health other than in a professional capacity? If yes, in what capacity?
- Understanding of mental health? What does it mean to you? Please indicate the sort of behaviour or symptoms a person would have that would indicate a mental health problem.
- Which of the following do you believe to be a mental disorder? – schizophrenia, alcoholism, amnesia, paranoia, stress, mental handicap, drug addiction, autism, pre-menstrual syndrome, Alzheimer’s disease, mania, learning difficulty, personality disorder, epilepsy, anorexia nervosa, psychopathy, dyslexia, depression, cerebral palsy, phobia, psychosis

- Which of the following do you believe may be a sign that a person is mentally disordered? – Verbally aggressive behaviour, inability to read, self-mutilation, untruthfulness, mode of dress, restlessness, inability to write, drunkenness, attempted suicide, physically aggressive behaviour, facial expressions, violence, does not answer questions, talkative, inconsistent statements, anxiety.

6. **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

*Ask the following depending on what service they are representing:*

- For **non drug services:**
  What about the referrals you receive from drug treatment services, how do these work in practice? Would you say that they worked well or do you think that there are areas for improvement?

- For **non mental health services:**
  What about the referrals you receive from mental health services, how do these work in practice? Would you say that they worked well or do you think that there are areas for improvement?

- For **non criminal justice services:**
  What about the referrals you receive from the criminal justice system, how do these work in practice? Would you say that they worked well or do you think that there are areas for improvement?

- **Decision making**
  - Process for allocating treatment places
  - Who are the key players
  - Availability of key information
  - Risk assessment
  - Service user involvement
• Adequacy of process
  o Suitability of client referred
  o Level of formal / informal monitoring
• Referral routes (and sources from treatment) to other services, e.g. treatment agencies, mental health services, housing support, employment support, family/peer support and criminal justice agencies
  o Referral routes for drug users with multiple co-existing problems? What are these referral routes? Process? Are these routes sufficient?
  o Who makes referrals
  o What kinds of services
  o Availability (waiting list issues)
  o Response from “other agencies”

SECTION 2: CLIENT SPECIFIC QUESTIONS (to be asked of those that were identified by the service user participant)

[Questions in this section will depend on the analysis of service user interviews and examination of individual case notes]

7. Barriers / facilitators to accessing treatment for MCP

Aim: To explore the individual, structural and procedural barriers and facilitators to access treatment for MCP.

Invite the participant to think about the service user who identified them as having an impact on their treatment. Briefly describe the nature of the case and probe for the following:

Referral
• Impact of referral route
  Probe for comment if CJS referrals
• Agency involved
• Suitability of treatment to individual case
• Decision making
  o Allocation to individual workers
  o Adequacy of referral process
• Referrals to other agencies
  o What referrals were made? What kind of services?
  o Process of referrals
  o Who made the referrals?
  o Was the referral route sufficient?
  o Response from other agencies?
  o Adequacy of referral process
**Treatment**

- Attendance
- Engagement
- Group process (*where applicable*)

- The extent and range of relationships between the agency interviews and different agencies in this case. For each agency relationship, describe…
  o The purpose of the relationship
  o Frequency of contact within treatment
  o How the relationship was conducted (face-to-face, telephone-conference, email)
  o Perceived effectiveness of relationship in relation to this case

**Reflections**

Reflecting on the case examined, ask participant to explore:

- Would changes to any procedural or practice aspects impact on treatment accessed and received
  o Explore nature of proposed changes
  o Who should contribute to re-design

**SECTION 3: CLOSING COMMENTS** *(to be asked of all service provider representatives recruited in the study)*

**9. Perception of Role**

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

- Personal motivators for working with drug users with multiple co-existing problems
  o Retaining factors
- Development and supervision (training)
  o Need
  o Source
  o What received
  o Impact
  o Extra training?
- Impact of work
  o Self
  o Colleagues
  o Family
  o Friends
- Agency goals
What do you see as your goals at an agency level and at a personal level in relation to the treatment of drug users with multiple co-existing problems?

- Agency values
  - What do you see as your values at an agency level and at a personal level in relation to the treatment of drug users with multiple co-existing problems?

- Agency responsibilities
  - What do you see as the agency’s responsibilities to a client with multiple co-existing problems? Do these differ from yours?

- What are the biggest challenges facing providers (probe for funding / targets / staff – client ratios)
  - Solutions to overcome
  - What can we learn from their experiences

- What are the biggest rewards for providers of drug treatment services

- Any other closing comments
Appendix H: Strategic leads interview topic guide

Strategic Leads Interview
Topic guide

As this is an exploratory study, participants will be encouraged to discuss their views and experiences in an open way without excluding issues which may be of importance to individual respondents and the study as a whole. Therefore, unlike a survey questionnaire or semi-structured interview, the questioning will be responsive to respondents’ own experiences, attitudes and circumstances.

The following guide does not contain pre-set questions but rather lists the key themes and sub-themes to be explored with each group of respondents. It does not include follow-up questions like ‘why’, ‘when’, ‘how’, etc. as it is assumed that respondents’ contributions will be fully explored throughout in order to understand how and why views, behaviours and experiences have arisen. The order in which issues are addressed and the amount of time spent on different themes will vary between individuals and according to individual demographics and dynamics.

SECTION 1: STRATEGIC FOCUSED INTERVIEW QUESTIONS

Introduction
Aim: To introduce the research

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

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 i.e. previous experience etc
- Description of service / agency / organisation
• Organisational structure
• Roles and responsibilities within organisation

**Context of organisation**

• How does the organisation fit into the local configuration of providers and services
• What services do you provide for drug users
• Organisational culture – development of service or organisation
  o Aims and goals of organisation
  o Values of organisation

**Multi-agency working**

• What does multi-agency working mean to you? And what impact does it have on your role?
• Types of services that you work and liaise with
  o Nature of relationship
  o Frequency of contact
  o How the relationship is conducted
  o Quality of relationship (formal/informal)
• Process for developing and maintaining effective multi-agency working – what is done at an agency level for example
  o Formal policy – are services integrated or do you still feel separated from other services?
  o Barrier / facilitators to effective working
• Perceived impact of multi-agency working
  o Impact on colleagues
  o Impact on clients
  o Overall impact on outcome
  o Advantages/disadvantages?
• Training

**Aims and goals**

• Reiterate the aims/goals of agency/organisation, how do these fit in with or relate to drug treatment?
• How are aims and goals of multi-agency/collaborative efforts established, if at all?
  o Is this the case for drug treatment
• And how are they managed?
  o Is this the case for drug treatment
Leadership

- Who takes the lead in collaborative efforts? And what about drug treatment

Role in relation to drug treatment

- What is your operational/strategic role in drug treatment?
  - Membership on DAT
- How do you prepare for meetings relating to drug misuse? What do you prepare? And what contributions do you make?
- Do you feel that you are able to contribute everything that you need to
- Rate the extent to which you’re involved in drug treatment 1-5?

SECTION 2: OPERATIONAL FOCUSED INTERVIEW QUESTIONS

(Do not ask representatives of NTA or DAT)

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 service
  - Who makes referrals

Ask the following depending on what service they are representing:

- For non drug services:
  What about the referrals you receive from drug treatment services, how do these work in practice? Would you say that they worked well or do you think that there are areas for improvement?
- For non mental health services:
  What about the referrals you receive from mental health services, how do these work in practice? Would you say that they worked well or do you think that there are areas for improvement?
- For non criminal justice services:
  What about the referrals you receive from the criminal justice system, how do these work in practice? Would you say that they worked well or do you think that there are areas for improvement?
• Decision making
  o Process for allocating providing services
  o Who are the key players
  o Availability of key information
  o Risk assessment
  o Service user involvement

• Adequacy of process
  o Suitability of client referred
  o Level of formal / informal monitoring

• Referral routes (and sources from treatment) to other services, e.g. treatment agencies, mental health services, housing support, employment support, family/peer support and criminal justice agencies
  o Referral routes for drug users with multiple co-existing problems? What are these referral routes? Process? Are these routes sufficient?
  o Who makes referrals
  o What kinds of services
  o Availability (waiting list issues)
  o Response from "other agencies"

SECTION 3: CLOSING COMMENTS (to be asked of all service provider representatives recruited in the study)

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

• Personal motivators for working with drug users with multiple co-existing problems
  o Retaining factors

• Agency goals
  o What do you see as your goals at an agency level and at a personal level in relation to the treatment of drug users with multiple co-existing problems?

• Agency values
  o What do you see as your values at an agency level and at a personal level in relation to the treatment of drug users with multiple co-existing problems?

• Agency responsibilities
  o What do you see as the agency’s responsibilities to a client with multiple co-existing problems? Do these differ from yours?

• What are the biggest challenges facing providers (probe for funding / targets / staff – client ratios)
  o Solutions to overcome
o What can we learn from their experiences
  • What are the biggest rewards for providers of drug treatment services
  • Any other closing comments
Appendix I: Biographical profiles of service users

Kevin is a 40 year old, white, unemployed, primary heroin user who lives in rented accommodation supported by NACRO. He started using heroin at the age of 22. His first treatment experience was at the age of 24 where he received a methadone prescription. He remained in treatment for approximately 10 months but then was asked to withdraw as his workers suspected that he had not been taking his methadone. Kevin soon began to use heroin again but in 1998 sought treatment for the second time where, again, he was in receipt of a heroin prescription. While in contact with treatment Kevin was convicted of robbery and received a prison sentence. He continued to receive methadone while in prison and after four months was released into the community and given a naltrexone prescription but after two months relapsed. This cycle of drug use, treatment, offending and prison continued until 2004 when he moved areas and was placed on a shared care scheme. He has been receiving a methadone prescription since.

Reece is a 30 year old, white, primary heroin user. He is single and lives in private rented accommodation. He has had a difficult upbringing. He was sexually abused as a child and has been self-harming since in his early teenage years. He also has a long-standing history of depression. Reece began using substances at the age of 11 when he was thrown out of his family home. He experimented with alcohol, cannabis, speed, acid and cocaine. Then, at the age of 21 he began using heroin. Reece’s first treatment experience was at the age of 24 where he was provided with a methadone prescription. He continued to use heroin on top of his prescription and was soon convicted of theft and given a prison sentence. Upon release from prison he began using heroin again and soon referred himself into treatment where, again, he received a methadone prescription. His drug taking and offending, however, continued and he was quickly sent back to prison. This cycle of drug use, treatment, offending, and prison continued until he moved area after being released from a 11 month prison sentence. Upon release Reece was put on a license attached to which was a condition to attend treatment. It was at this point that Reece was first interviewed.
Claire is a 33 year old, white, unemployed, primary heroin and crack cocaine user. She lives in private rented accommodation with her partner and son where they have resided for approximately nine months. She began experimenting with drugs when she was at school and started using heroin at the age of 19. Her first experience of treatment was at the age of 19 where she received a methadone prescription for six months. After this period of treatment she was in recovery for approximately 12 years. Her drug taking started again when she met Wayne (below). At the time of interview she had been in treatment for one year but was still using heroin once a week.

Wayne is a 40 year old, white, unemployed, primary heroin and crack cocaine user. In addition he frequently uses benzodiazepine. He lives with his partner, Claire (above). He started using substances at the age of 14 experimenting with glue, amphetamine, LSD, ecstasy and cocaine. He started using heroin and crack cocaine at the age of 18. His first treatment experience was at the age of 18. At this point Wayne was given a prescription for methadone and diazepam. While attending treatment, however, he continued to use on top of his prescription. After 6 months he was convicted of shoplifting and went to prison for 6 months where he continued his use of drugs. Upon release he continued to use and after two months presented to treatment where he was given another prescription for methadone. Like before though he carried on using on top of his prescription and was soon convicted again of another offence and sentenced to imprisonment. This cycle of drug use, treatment, further drug use, offending, and prison continued for approximately 13 years until he was given a Drug Rehabilitation Requirement in 2006. At the time of his first interview he had completed his DRR but was still attending treatment and in receipt of a methadone prescription. He was, however, still using heroin on top of his prescription.

Jill is a 27 year old, white, unemployed, primary heroin user. She lives in private rented accommodation with her partner and her seven year old daughter where they have resided for four years. Jill began using heroin at the age of 25 and used continuously for 18 months while working full-time. Upon conviction of a fraud offence she was then given a DRR. It was at this point that Jill was first interviewed.
Adele is a 35 year old, white, unemployed, primary heroin user. She is homeless and at the time of first interview was staying with a friend. Adele started using heroin at the age of 17 and started using it daily at 19. It was at this point that Adele had her first treatment experience where she was put on to a methadone reduction programme. After completing this programme Adele was abstinent for seven years but began using heroin again after her mother died in 2001. Adele then started on a cycle of drug use, treatment, offending, and prison that lasted for approximately five years. In 2008 she was given a DRR which she was subject to at the time of her first interview. Adele has a long history of depression and has attempted suicide on several occasions.

Jon is a 33 year old, white, unemployed, primary heroin user. He lives in private rented accommodation with his partner and has resided there for approximately three years. Jon started using amphetamines at the age of 17 when he was earning a living as a dealer of drugs. His drug use became problematic, however, at the age of 26 when he started using heroin. Jon attempted to access treatment at his GP practice almost immediately after his heroin use began but was told to go away. It was at this point that Jon took an overdose and was subsequently referred to a psychiatrist. He finally accessed community treatment at the age of 28 and has been in and out of treatment since. At the time of interview he was in receipt of a methadone prescription.

Joe is a 29 year old, white, recovering heroin user. He is single, lives with his mother, and works as a volunteer for the service user forum. Joe began using drugs at the age of 12 experimenting with cannabis. By the age of 15 he was using LSD and amphetamine. Joe began using heroin at the age of 17. At the age of 21 Joe had his first treatment experience. After four months, however, Joe relapsed and continued to use drugs while in receipt of his methadone prescription. This cycle of drug use, treatment, relapse continued until he was 27 when he was given a probation order for theft from his employer. By 2009 Joe had become abstinent from all drugs.
Susan is a 43 year old, white, recovering heroin user. She is single, lives in private rented accommodation, and works as a volunteer for PALS. Susan began using drugs at age 18 experimenting with heroin, crack cocaine, and benzodiazepine. At the age of 19 she sought treatment and followed a reduction methadone programme lasting two weeks. She relapsed almost immediately and then went into a residential rehabilitation centre. Upon exit from rehab she was in recovery for 5 years but then relapsed when her partner at the time began using in the 1993. After 10 years of consistently using heroin as her main drug of choice she sought treatment and began receiving a methadone prescription. It was in 2008, after discovering that she had contracted Hepatitis C, that Susan became abstinent from all drugs. At the time of her first interview she had been in recovery for 12 months.

Stuart is a 38 year old, white, unemployed, primary heroin and crack cocaine user. He lives in supported accommodation. He started using substances at the age of 12 experimenting firstly with solvents. At the age of 14 he began using cannabis in an effort to address the ‘voices’ he was hearing. By the age of 16 he was using both heroin and crack cocaine on a frequent basis. At the age of 20 Stuart sought treatment for his substance use problem and was given a methadone prescription. Like others, however, he continued to use heroin on top of his prescription and was soon convicted of an offence and sent to prison. While in prison he became clean from drugs but upon release he began using again almost immediately. He then sought treatment again where he was given another prescription for methadone. Like before though he carried on using on top of his prescription and was soon convicted again of another offence and sentenced to imprisonment. This cycle of drug use, treatment, further drug use, offending, and prison continued for approximately 17 years. At the time of his first interview he was subject to a DRR.

Zoe is a 35 year old, white, unemployed, primary heroin user. She has a partner but currently have no fixed abode. Zoe started using heroin and crack cocaine at the age of 30. She had previously smoked cannabis but her use was never a problem for her. At the time of her interview Zoe was subject to her 4th DRR.
**Jenny** is a 43 year old, black, unemployed, primary heroin user. She is single and lives in local authority housing with her 8 year old daughter. Jenny started to use drugs at the age of 16. At the age of 19 she had her first treatment experience from her GP who prescribed her with methadone and valium. By the age of 24 Jenny had started on the cycle of drug use, treatment, offending, and prison but reports always being on some form of substitute prescription. At her interview Jenny was attending treatment as a result of a DRR. Jenny has a long standing history of depression.

**Jamie** is a 29 year old, white, unemployed, primary heroin user. He lives in local authority accommodation with his partner and two children. He started using heroin at the age of 17 but reports that his use became problematic at the age of 23. At the age of 25 Jamie was diagnosed with depression after attempting suicide. At 29 he referred himself for his first ever treatment but received a subsequently received a DRR for an offence he had committed 12 months previous. It was at this point that Jamie was interviewed.

**Marie** is a 33 year old, black, unemployed, primary crack cocaine user. She lives in local authority housing. Marie started using crack cocaine at the age of 13 and heroin at the age of 15. By the age of 17 Marie had already began the cycle of drug use, treatment, offending, prison until 2008 when she was released from prison and placed on a methadone maintenance prescription. It was at this point that Marie was interviewed. Marie suffers from a number of physical health problems including arthritis which prevents her from keeping her appointments.

**Jim** is a 60 year old, white, unemployed, primary amphetamine user. He is married but has been separated for 10 years and currently resides in supported accommodation. By the age of 25 Jim had his own business but, at the same time, had started to use drugs quite problematically, his main problem drug being amphetamines. His drug use continued but he did not access treatment until the age of 50 where he first received a methadone
prescription. Jim continued to use on top of his medication. At the age of 58 he was then given a DRR by the court. It was at this point that Jim was interviewed.

Karen is a 22 year old, white, unemployed, primary heroin user. She lives in rented accommodation with her partner and their daughter, and has resided there for approximately 12 months. Karen began using heroin at the age of 20 and accessed treatment at the age of 21 through a self-referral. After 2 weeks Karen withdrew from treatment but accessed it again at the age of 22. It was at this point that Karen was interviewed.
Appendix J: Biographical profiles of service providers

**Beverley** is a Senior Substance Misuse Practitioner at a Specialist Prescribing Clinic and had been in this post for five years at the time of interview. Before that she worked as a Phlebotomist in a GP surgery which involved taking bloods from injecting drug users. Beverley’s main role is as a GP liaison and at the time of interview she had 78 clients on her caseload.

**Graham** is a Senior Substance Misuse Worker within a Specialist Prescribing Clinic and had been in this post for six years at the time of interview. Before that he worked as a Probation Officer. At the time of interview Graham had 45 clients on his caseload, each having a serious dependency on heroin and/or other Class A drugs.

**Kelly** is a drug worker within the core team at a Specialist Prescribing Clinic and had been in this post for four years at the time of interview. Before that she trained as a social worker and worked as a probation officer for nine years and six months. At the time of interview Kelly had 45 clients on her caseload, all of them either heroin, crack cocaine or amphetamine users. Most of these she sees on a fortnightly basis. Other, more stable clients she sees once a month.

**Ann** is a Drug Intervention Programme Manager within a Specialist Prescribing Clinic and had been working as a substance misuse worker for approximately nine years. During her time as a substance misuse worker she had worked in the alcohol team, in the core drugs team and more recently in the criminal justice team. Before that she trained as a Mental Health Nurse.

**Sarah** is a Criminal Justice Treatment Worker within a Specialist Prescribing Clinic and had been in this post for four years at the time of interview. Sarah trained initially as a social worker.
Fiona is a detox nurse within a Specialist Prescribing Clinic and had been in post for three years. Her main role is to facilitate detox whether it be a hospital or community detox. Prior to this she worked as a mental health nurse for her local NHS trust.

Bill is a Substance Misuse Liaison Nurse within a Specialist Prescribing Clinic and had been in post for four years at the time of interview. His main role is to hold a caseload of clients that attend the clinic and to see referrals from hospital wards.

Tim is a Senior Substance Misuse Practitioner within a Specialist Prescribing Clinic. Tim is, however, part of the Criminal Justice Team, specifically the Prison Release Team. His main role is to link people who are released from prison into local services. He had worked in this post for five years at the time of interview although had been working in the substance misuse field for over 20 years.

Margie is a Senior Substance Misuse Practitioner within a Specialist Prescribing Clinic and had been in post for four years at the time of interview. Much of her role involves working with criminal justice clients; clients subject to a court order. Before that Margie trained as a family support worker supporting the families of substance users.

Karen is a Senior Substance Misuse Practitioner within a Specialist Prescribing Clinic. Her main role is as a nurse for a methadone scheme. She has been working in her current role for two years but had prior to that worked as a generic drug worker. Before her role as a drug worker Karen trained as a Mental Health nurse and went on to train as a drug worker in a prison.

Tony is a regional manager for the National Treatment Agency. At the time of interview Tony had been working for the NTA for nine years. Before that he had worked for regional government and a registered charity with experience of managing drug services. Tony has worked within the drug treatment field for over 20 years.
**Janet** is a Probation Officer working in the intensive contact team. Her role is to work with prolific offenders and drug users who are subject to a Drug Rehabilitation Requirement. She has been working in her current role for five years.

**Julie** is the Substance Misuse lead for the DAT (East Town). Her role is to commission and performance-manage substance misuse services in her DAT area. Julie had worked at the DAT for 7 years beginning her career in the drugs field as a Planning and Commissioning Assistant. Before that she had worked as a social worker.

**Hayden** is a Substance Misuse Service Manager in East Town. He is responsible for the management, performance-management, and service delivery of all the services his employer provides in the district. Hayden began his career as a social worker in 1989. Before joining the substance misuse team in 2004 he had worked as a mental health social worker and drug worker.

**Andy** is a Senior Housing Strategy Officer in East Town. His main responsibilities are with the homelessness services, which involves monitoring the housing advice contracts and other initiatives connected to young people, hospital discharge protocol, and housing offenders.

**Simon** is an Information and Commissioning Policy Officer in West Town. His and his team’s main role is to commission effective substance misuse services. He has been in post for seven years. Before that he worked in the Drug Strategy team at the regional government office where he began his career.

**Keith** is a Drug Coordinating Sergeant for West Town. His main role is to lead on the Drug Intervention Programme. He has been in his current post for eight years.
Phil is a Consultant Nurse working in the field of dual diagnosis, a combination of mental health and substance use. At the time of interview he had been working in this post for eight years.