

Losing the Habit:
an investigation of DTTO clients'
experiences of mid term drop out

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Introduction

The Final Evaluation Report on the three DTTO pilots made bleak reading for anyone involved, as I was, in the Gloucester project

Evaluations usually set out to test whether a particular approach is effective, and often end up concluding that the approach was put into practice so poorly that one cannot draw any conclusions at all about effectiveness. In this instance we think that there is sufficient evidence to say that the approach is viable, but at one stage it looked to us as if our main conclusion would be about implementation failure. At different stages in their lives all three schemes struggled, and our judgement is that only one of the three (ie Croydon) ended up with a viable DTTO programme.

Turnbull et al, 2000

With hindsight, it is easy to see that one of the principal obstacles to achieving good working practice at the time was that staff were so rushed off their feet trying to keep up with the daily needs of the clients and the torrent of inward referrals that there was never time to reflect on what was happening and thus devise improvements.

The Gloucester team has come a long way since those dark days when staff drop out, on occasion, outstripped client drop out. A coherent service strategy in line with Chapman and Hough's (1998) principles of programme integrity has taken shape, accompanied by higher levels of attendance, and more satisfaction reported by service users (Clarke 2002).

Nevertheless many clients continue to drop out. Roughly speaking, a third fail to engage from the beginning. There has been some limited research into the reasons for early attrition, notably in residential settings, and this has led to some effective counter measures, for example the provision of induction programmes. Gloucester DTTO team does run an induction programme, and while there is undoubtedly scope for its further development, it benefits only those who attend. It seems likely that client, rather than treatment, characteristics play the major part in early non attendance. One could reasonably surmise that

- some clients are on a prison swerve
- some clients change their minds about wanting drug treatment
- some clients undergo a change in their circumstances

and while research into these factors may throw up important recommendations for the assessment process, it is less likely to cast light upon the service provision as a whole.

It was therefore decided to investigate the cohort of clients who achieve, and maintain, some level of engagement for the first few months, and then drop out mid-term. Our records tend to cite resumption of drug use, criminal activity and non attendance as the factors behind a request for revocation. These are stark indicators, ideal for presentation in a court hearing where decisions are made on the basis of what has been recorded and can be verified. At this point the client's narrative, which hitherto we have been busy listening to, evaluating, empathising with, becomes stripped of its complexities and nuances. Did you attend on that day or not? Did you test positive to opiates or not?

Might there be some value, then, in eliciting the client's story of how it all came about? What might we have missed? What inferences might we be able to draw about how to manage this particular crisis in the client's life more effectively?

The Final Evaluation Report offers an interesting point of comparison. Back in the days of the pilot, 19 offenders (all but one of whom happened to be from Gloucestershire) cited the following factors as affecting their ability to keep within the requirements of the order:

- too difficult to stop using drugs
- type of treatment or way in which care provided was unhelpful
- inadequate levels of prescribing
- poor levels of support
- others using on the programme
- disagreements between staff
- too far from home
- personal circumstances, eg childcare responsibilities, drug using partner

The three factors they identified that would have helped them to keep to the conditions of the order were

- a higher level of prescribed drugs, for longer
- being given more time to make changes
- the opportunity to move away from drug using partners and associates

It would be interesting to see whether, on these measures, the experience of non-completing clients had changed. Furthermore, a mere 16% (3 out of 19) of the above sample reported that they had benefited from the order: did this figure remain representative?

Review of the literature

The aim of the study was to identify some of the factors influencing clients to leave the programme in the middle stages of their order. By listening to the accounts clients gave of this process it was hoped to gain a fuller picture than might be revealed in the official records. Were there influential factors in their own lives, or in the programme we were running, whose significance at the time we had been unable to appreciate?

Although orders can be made only with the participant's assent, DTTO programmes come under the umbrella of what the literature calls "mandated" or "coerced" treatment. To begin with, various North American attempts to enforce treatment attendance foundered, but it was soon clear this was because projects were generally poorly thought through, housed in unsuitable buildings, managed by bureaucrats without treatment expertise, lacking clinically experienced staff, and without a mechanism for ongoing evaluation and improvement (Inciardi 1988).

As these lessons were slowly incorporated into fresh initiatives involving health and criminal justice partnerships during the 1980s there was a gradual acceptance that coercion could play a significant part in coaxing participants into staying in treatment longer. De Leon elaborates three crucial stages in the process of rehabilitation as being

- compliance – adherence to the rules and regulations of the treatment centre to avoid negative consequences such as disciplinary sanctions, discharge, or reincarceration;
- conformity – adherence to the expectations and norms of the group or community to avoid loss of approval or disaffiliation; and
- commitment – adherence to a personal resolve to change one's lifestyle

and describes the potentially pivotal role of legal sanctions in assisting progress through the programme

compliance can lead to rehabilitation when legal pressure maintains compliance during the transition to the conformity and commitment stages in the recovery process

(De Leon, 1986)

Leukefeld and Tims (1986, 1990) broadly agree with De Leon that length of time in treatment and post-treatment outcomes are similar for those with and those without legal status. The supposition is that while offenders may initially be more resistant to treatment, coerced attendance offsets their tendency to drop out. Thus external (legal) pressure may be insufficient basis for a client to make lasting changes, but has an important role to play in influencing a person to remain in treatment while motivation and commitment develop.

A survey by Collins and Allison (1999) of 2,276 individuals who entered out-patient drug-free and residential services had similar findings, that clients who are legally induced to seek treatment remain longer than, and do at least as well as, those who seek treatment voluntarily.

In their survey of response to treatment by 121 attenders, McLellan and Druley (1977) found no significant differences between court referred and voluntary drug patients. They note that while court referred patients may be initially more withdrawn, by the later stages of treatment they are as responsive and actively engaged as voluntary patients.

A comparison study of the Abraxas therapeutic community whose clients are almost exclusively court referred found that court pressure can significantly enhance retention rates, particularly during the early stages of treatment (Pompi and Resnick, 1988).

Similarly, Miller and Flaherty (1999) find that

effective therapeutic interventions and long-term recovery are more likely to succeed if avoiding "alternative consequences" is contingent on continued compliance with addiction treatment.

Farabee et al (1993) found that the 136 criminal justice referrals in their psychosocial profiling study scored significantly lower in their assessment of drug problems, desire for help, and readiness for treatment, when compared to 40 voluntary attenders on an out-patient programme. Drawing on the cycle of change model developed by Prochaska and DiClemente (1988), they call for investigation of how the motivation of offenders in drug treatment programmes might be enhanced rather than relying on the influence of courts.

Young and Belenko (2002) conducted a comparison study of retention in three different models of U.S. mandatory drug treatment and found that the odds of clients remaining in treatment for six months or more were nearly three times greater in the most coercive programme compared to clients in the third group.

Young and Belenko (ibid) were of the opinion that coercive elements were best deployed however when there were *clear protocols for informing clients about the legal consequences of their participation and how that participation would be monitored*. In a separate study Young (2002) concluded that coercive approaches were effective provided that clients were clearly informed about conditions and contingencies of participation and sufficiently convinced that measures would be enforced.

Accepting then the consensus that elements of coercion can help to retain clients in treatment, what other factors have been identified? Broadly speaking, researchers have occupied themselves with assessing the relative impact of client characteristics and treatment characteristics.

Grand (2001) suggests that working with clients' *implicit beliefs* about their substance abuse problems may be useful at an early stage in treatment programmes. Lack of confidence in their ability to change renders clients susceptible to early drop out and this may be helpfully addressed by interventions focussing on building confidence and motivation.

Moeller et al (2002) identify *impulsivity* as a significant predictor of cocaine use and treatment retention and suggest the need to target impulsivity in cocaine dependence treatment.

Dobkin et al (2002) found that *levels of social support at intake* were a significant predictor of retention in treatment, though not a predictor of reductions in drug use.

Conversely Saarnio (2002) identified *more frequent contacts with problem drug users* with less likelihood of treatment completion, particularly in the case of younger clients.

According to Fiorentine et al, however, treatment rather than client characteristics seem to offer stronger possibilities for predicting client retention (Fiorentine et al 1999, De Leon 2001).

Secades-Villa and Magdalena-Benavente (2001), in a study of 52 heroin dependent men, concluded that *events occurring during treatment*, rather than patient characteristics, significantly affected patient retention in substance abuse treatment.

Many commentators describe the significance of client-staff relationships, an in-treatment factor, in maintaining continuity of treatment. De Leon (2001) and De Weert-Van Oene et al (2001) place *the helping alliance* at the centre of treatment retention factors.

Joe et al (2001), examining therapeutic relationships from the practitioner perspective, concluded from their study of 577 patients undergoing drug treatment that *levels of rapport* were significantly associated with good outcomes and helpful in explaining why and when treatment was effective.

McCaul et al (2001) made an extensive study comparing patient and treatment characteristics as predictors of outpatient substance misuse treatment. They decided that a key, and often underrated, determinant was *the ability of services to match patients' needs* – especially in the domains of culture, gender and vocation.

Closer to home, Chapman and Hough (1998) emphasize *programme integrity* as a significant variable in treatment outcomes, stressing that clients need to be properly informed about what is expected of them and that programme delivery needs to be consistent with its core values and objectives.

Overall then, researchers have taken the view that coercion can, at least in the critical first period of three months or so, significantly help participants to remain in treatment. Characteristics pertaining both to the treatment and to the client have likewise been identified as helpful to retention, and this process of identification itself has been helpful to providers interested in improving the quality of treatment on offer.

Methodology

Careful consideration was given to the matter of how best to collect data in a way that would both do justice to the experience of the informants and provide a commentary on the DTTO programme that might be interesting and useful to the practitioners. As with most research studies this involved a degree of compromise between what was desirable (specific, detailed, informative) and what was feasible within the constraints of available time and resources.

Of particular concern to me was the question of ownership of this research. To have a chance of some abiding interest and relevance for the Gloucester team it needs to represent a view or views that are important to the team's underpinning philosophy. If therefore I was going to be asking about the impact of specific interventions or processes such as assessments, testing, prescribing, groupwork, counselling, sports and leisure activities, ETE, court reviews and so on, or if I was going to ask about the impact of more general features such as how people were affected by the location, the building, the peer group, the prevailing culture, then it would have been crucial to engage my team colleagues in consultation as to what was best explored and how. The need to work to a deadline, regrettably, made this unfeasible.

This illustrates a parallel concern: the ease with which opportunities for reflection on working practices can be elbowed out of the team timetable by the seemingly endless difficulties that problem drug users tend to bring in their wake and the similarly exacting demands for accompanying paperwork. Observing how all three pilot DTTO projects floundered during their first 18 months, the DTTO Final Evaluation Report (Turnbull et al 2000) makes it clear that monitoring and evaluation systems need to be built into programme design right from the start, along with opportunities for teams to reflect upon and thereby improve their working practice.

A cruel irony of the Gloucester pilot, in my opinion, is that opportunities for this sort of reflective discussion were systematically drowned out by a very narrow interpretation at managerial level of the “What Works” agenda. This literal, even slavish, adoption at local level of national policy which continuously exhorted us towards “evidence based practice” recognized neither individual practitioners’ experience, nor the long experience of specialist seconding agencies and their managers, nor the accumulating collective experience of the team – all of which necessarily constitute evidence of the most relevant and directly applicable kind. The commissioning of this present, albeit very small scale, study illustrates a welcome sea change in managerial perspective, in line with the PDSA model of organisational change now being vigorously promoted by NIMHE (NHS 2002).

It is important to mention that, although I have been with the Gloucester DTTO team since the very beginning, this study is my last contribution before the secondment closes. There will be little or no opportunity in the workplace for other team members to explore with me why data is presented or interpreted in particular ways that others find vexing or controversial. On one hand this is a liberating influence in that I am free to say what I wish with only a slight chance of subsequent repercussions. On the other it enjoins me to be as transparent as possible about the “decision trail” – how choices about what to include or exclude were made in order that readers can sift for themselves what is the data and what the researcher’s overlay (Koch 1994). A less than transparent study will soon finish up in the recycle bin. If it is to have the chance of any influence then it needs to embody the same level of integrity it recommends for the treatment programme.

McLeod for example highlights the importance of research being presented as ‘knowledge-in-context’ if it is to be incorporated into practice. While researchers in this field are often practitioners themselves with a sure grasp of their material, their perceived demands of the establishment, in this case The Probation Service, may cause them

to report their results in an abstract, impersonal and disembodied style. The effect of this is to make it impossible for the reader to understand why the researcher did the research in the first place, what it meant to him or her, and how it influenced their subsequent practice.

(McLeod 1999)

For this reason I have found myself veering away from the idea of a statistical analysis of treatment or client variables. In any case there is a gathering view among social science researchers that purely quantitative studies have limitations when it comes to casting light upon the nuts and bolts of relational processes that are by their nature individual and ever changing. There is a burgeoning process-outcome database which explores in great detail, sometimes with huge samples, the impact of different protocols and interventions on particular client groups (see, for example, Project Match, 1997) with sophisticated randomization and standardization techniques. What is more difficult to pin down is the possible impact of our own protocols and interventions on our own client group in this setting. We can look back at our records, we can list what we said and what we did and observe what happened, making reasonable deductions about cause and effect. We know how it went down with us, we know how it went down with the courts, but how did it go down with the clients? Even if there was a close match at the time between what we thought it meant and what they thought it meant, how about now? Have they moved on, or are they stuck? Have we moved on? Or are we stuck?

The best chance therefore of eliciting data that was meaningful to this particular DTTO team at this particular time seemed to pursue a qualitative approach, which might encourage my informants to express their views and recollections in their individual ways. I wanted at all costs to avoid simply shoehorning their experience into research paradigms (eg, using a scale of 0 to 10 how do you rate?) determined by me, the researcher. After all, we already had one record of each client's experience in the shape of official files, logs, and reports: these constitute the particular versions of reality that appealed to staff members at the time of recording. The central challenge, it seemed to me, was to see whether the clients had a different version, and if so, what we might be able to learn from it?

A major thrust of NTA policy at this time is to encourage drug treatment providers to hunt out the views of service users.

The NHS and Social Care Act 2001 demands that every NHS body, including drug treatment services, now has a statutory duty to consult and involve patients and the public in its activities
(Models of Care full reference report 4.6.1)

The challenge for all publicly funded treatment agencies at this time is to become service user rather service led. In a research study conducted on our doorstep in Gloucestershire last year this challenge was taken to heart by one researcher who trained service users to conduct the interviews themselves (Clarke 2002).

Diminishing in this way the possibilities for the researcher, and the agencies she represented, to influence the conversations with informants was a courageous step in the direction of restoring the power relations between the two parties to a more equitable balance.

It was also time consuming and thus outside the scope of this present study. The narrative technique I have adopted here does, however, place issues of power and influence at the heart of its methodology. Each of the five informants had some recollection of me, the interviewer, as a member of the DTTO team, and therefore as having been in a position to influence decisions about enforcement, breach action and other matters with the potential to affect their daily lives. While I prompted conversations about this with each subject and stressed that my record of what they chose to tell me would in no way influence present or future legal proceedings or relationships with criminal justice agencies, Speedy (1998) reminds us that simply putting power inequalities on the table by no means causes them to vanish.

The purpose of the study – to investigate mid term drop out – was already established. But drop out from which phase of a programme that had been evolving since 1998? The Gloucester DTTO programme had undergone a period of particularly rapid change and development following the arrival of a new manager in the summer of 2000. This suggested that quite apart from the difficulties in tracking down people whose orders had been prematurely terminated in the period to the spring of 2002, and the probability that recollections of their experience at that time would now have been dulled, informants would be best sought from the DTTO programme in a recent stage of development. I decided to target only individuals whose orders were terminated in the period April – September 2002.

To select informants, each of the three Probation Officers was asked to come up with a list of clients whose orders had been revoked somewhere in the middle stages during the previous 12 months. Out of the dozen selected, seven either didn't reply to my invitation to take part or proved impossible to trace within the timescale. Of the five who responded, all agreed to take part. Two were living at

home and agreed to come into the DTTO programme site for interview while the other three were interviewed in prison.

In agreement with the research commissioner, I decided to pay each informant £15 – a sum large enough I hoped to be respectful of their giving up their time, but not so large as to entice grateful attempts to supply me with the right answers. Once we had met for the interview, I stressed to informants that they would now be paid irrespective of whether they chose to say anything or not, and whether they chose to stay in the interview, or not. In addition, they were free to change their minds after the interview, and were entitled simply to withdraw all that had been said from the data pot. In fact none of these options have, at this point, been exercised.

The interviews themselves were of semi-structured format and in three distinct phases. The first was to talk through the issues described above, to explain the purpose of what we were doing, to encourage candid responses, and generally to enquire about the informant's current wellbeing. The third was to effect closure, by appreciating their willingness and candour, by supporting their continuing efforts to make sense of and learn from the DTTO experience, and, where appropriate, to encourage the seeking out of support from local agencies or Carat teams.

The second stage covered four questions:

- What led up to revocation of the DTTO?
- Was there anything you would have liked us to do differently?
- Was there anything you would have liked to do differently?
- In what ways have your thoughts and feelings about the DTTO changed since that time?

Only this part of the interviews was digitally recorded and then transcribed. The data was then subjected to processes of selection and arrangement, with conceptualisation and categorisation taking shape as the study progressed (Dey, 1993).

Once the full texts were available for analysis it became clear that of the five subjects, two (S1, S4) felt that their lives had moved on in positive ways. S1 had now achieved, and was sustaining, his goal of abstinence from class As in the community. S4 claimed to be abstinent from all drugs, had volunteered for a drug treatment programme in prison, described an ongoing fruitful relationship with his Carat worker, and was clear about what he was going to do differently when back in the community. Both of these informants described their DTTO experiences as important steps in the process of making positive changes to their lives.

A third informant, S5, also in prison, did not ascribe positive benefits to his DTTO attendance, but neither did he feel that he had been treated unfairly. He was willing to take some degree of responsibility for what had gone wrong in the course of the order, but was unclear about what he could have done differently. He had positive plans for his release but it was difficult to see how effectively he would be able to resist the lure of Class As on his own resources.

S2 was continuing to use heroin in the community. There was considerably more acknowledgement of what he could have done differently than he had demonstrated in the latter stage of his DTTO, but there were some areas of his present demise that he felt others had brought about rather than himself.

S3 was in prison, looked well and claimed not be using any drugs. His account was markedly different from those above. It transpired that although his DTTO terminated after five months, this was the result of hold-ups in the sentencing process. He had only attended on a total of 15 days, and so the decision was made to exclude him from this study of mid term drop out.

The research data

initial motivation

I did really want to stop taking drugs but, more, I just wanted to get out of prison, I think, that's what it was really. I did wanna stop taking drugs, like every addict do wanna stop taking drugs, but I think it was the feeling that I didn't know how to I didn't know how to, didn't know how to. I wanted to, but I just didn't know how to. That's what it was really, I think (S4)

Yeah, in one way I wanted to do it, stay clean, you know, and um using is better than prison, you know? Cos first off I must admit one of the ... when I got mentioned on the DTTO I thought way out of the job, you know what I mean, cos it was a bit of a blag but when I got there and started doing it, I thought yeah, it was actually okay, (S5)

Informants supported the proposition that drug users are frequently ambivalent about wanting to stop. There is commonly a degree of scepticism among practitioners about statements such as "I definitely want to stop" or "I don't get using thoughts, relapse isn't a problem for me" especially at the time of assessment. These informants are presenting a realistic appraisal of their levels of motivation, and if it were hindsight making that possible then it may be that the DTTO experience had contributed to their presenting levels of self-awareness.

clear initial contracting

everyone was saying like, even the probation officers here was saying, as long as you do your 8 weeks you can walk out, it doesn't matter after that. And I walked out, well I got arrested for it and I had to go back to Court for it. For breach. Even though everyone was saying I can walk out after 8 weeks. (S2)

This was the only informant referred for residential treatment. It was made clear at the time of sentence that attending residential treatment was the condition under which a DTTO could be made. According to the records, this was a determining factor in helping him to see Stage One through to the end and in to the commencement of Stage Two.

It is unlikely that either DTTO or treatment centre staff would have suggested it would be all right for him to walk out after 8 weeks, but that was the narrative he recounted and the way he had ordered his experience.. The records suggest a possible explanation:

26.02.02 {my own entry in the contact sheets} "let him know it will be his responsibility to try and convince the community care assessor of his need/enthusiasm for 2ary funding".

The client here is placed in the middle of a paradox – devised not by himself, but by the system in which he found himself. On the one hand he has contracted to attend and engage with “treatment” as defined by his probation officer: in return he has been given a DTTO. The Stage One period was funded by the DTTO team itself and so its members could be crystal clear with him about the consequences of discharging himself. The Stage Two period however could only be funded out of the pooled treatment budget for the county. DTTO assessors are going to accept and work with the coerced attendance element to their advantage. Community Care assessors, on the other hand, are looking for evidence of a desire for and commitment to a period of treatment and both elements are going to be undermined by the presence of coerced compliance.

So while my wish to build this client’s sense of ownership of his treatment, and thus sense of responsibility, makes sense at one level, as does my wish for him to convince the assessor that his treatment is worthy of continued funding, at another it is therapeutic trickery. He cannot both *have* to attend treatment and *choose* to attend treatment.

head-on collisions

It was going okay for a bit you know but then like certain things in like in the group like acupuncture I hate, you know I don't like, so I refused to go to them, so you know I won't turn up, I don't like doing it well I didn't feel it was (ie compulsory) but (my probation officer) was forcing me to do it, you know, saying if I didn't do it I'd be breached, you know, so I sat there, I went there once, you know, just sat there with a few pins in my ears ... You know, and that still weren't good enough, do you know what I mean, to have pins in my ears, I wouldn't do it, so every time I had acupuncture I'd blag it and say there was summat wrong, and all that ... I'd make up something like, oh I've got to go to the DSS and I gotta keep going, so you know [S5]

Cos I was working while I was on the DTTO, that's one thing (my probation officer) didn't like, you know, cos I was working nights, all through the night and that, I didn't go in the day and (my probation officer) didn't like it you know telling me like what kind of work I could do, you know, I ain't having people telling me what kind of job I can do and can't do. I started using gear and then I got sacked because I knocked out the foreman and then I got sacked, then I started robbing to support my habit (S5)

Maybe I just turned around and said fuck you lot, you know. I'm not you know, you can't threaten me with, er, it's quite a big thing to have over your shoulders, you know, if you use again you're going straight back to Court, you know, so maybe that, I don't know. It wasn't a conscious thing, I don't think it was a conscious thing but maybe just something that, that on me shoulders made me say oh bollocks to it and off I went again. (S1)

somebody's telling you to go back to Court and you know that to me says they're against you more than trying to help you, I think (S1)

Since the autumn of 2000 when the incoming manager began to re-focus the team on the benefits of, where possible, taking a co-operative rather than adversarial position in regard to the clients, scenes of angry confrontation have become very much rarer. Where they do take place, staff have the opportunity for a deepening of their relationship with the client (eg Fitchie & Leary, 1998). It may be possible for a client with a long-held distrust of authority, perhaps related to a turbulent parental relationship, to resculpt their position when the staff member is demonstrating consistency, respect, and a readiness to manage effectively their own feelings. Or the release of pent-up emotion may signal the first stage in unlocking a vibrant emotional life that has been largely suppressed during drug use.

It is clearly less helpful when, as illustrated here, there is no sense of resolution and the client decides to keep quiet about aspects of their lives that staff perceive as unacceptable. Thereafter the client is presenting a sanitized view of themselves where the "fly-on-the-wall versions" are missing (McLeod 2000). The possibilities for genuine engagement diminish as the client's daily struggles recede from view.

resuming drug use

I was using heroin, I was on methadone still and no I didn't even need it, I had methadone to sort me out, but I was just getting a bit greedy [S2]

After a while I just stopped taking naltrexone. I woke up one morning and thought, I'm going to have a smoke this morning No, I wanted to do it, I wanted to do it for a while. While I was taking naltrexone, every day I wanted to do it. But I dunno what happened, that morning I just woke up and I just had money in my pocket and I was bored, that was what. it was a Sunday morning, I can remember it, and I just knew it was going to be a boring day and I just thought I'm going to have a smoke today and that was it, I just knew really [S4]

like I didn't mind doing it (the DTTO programme) until I started like using again, mixing with the wrong people sort of thing, started using then started going a bit downhill, started missing more and more groups, yeah, then I got breached [S5]

Well, I think I just started again you know probably just being around the wrong people, that's why I started again I think [S1]

All informants reported resumption of class A drug use as the major determining influence in the disintegration of their DTTO engagement. I was struck by how matter of fact, almost casual, were these descriptions of events that initiated the path back to resentence and, in three cases, imprisonment. Hammersley et al (2003) describe how the normalization of drug use in certain demographic groups, notably young offenders, has contributed to the complexities of fitting treatment provision to the needs of service users. They comment [p.70] that

for most young offenders at least substance abuse is neither the main cause of their problems, nor a subsidiary symptom that will naturally vanish when the other problems are treated.

justification for drug use

I thought, I won't take the tablet today, I'll take it tomorrow. I'll have a smoke today and take the tablet tomorrow, but tomorrow's never come now. [S4]

Cos addicts, they justify things like, 'well I've had an argument with so and so today so that gives me the right to go and use something'. And it don't – there's other ways around it, but when you're an addict even stupid little things, someone could say something wrong to you in the DTTO, like one of the members of staff, 'you're going to get breached if you carry on', and that'll justify it if you wanna use. 'Well I'm getting breached now anyway so I'm going to go and use'. It's just stupid really, know what I mean? Just stupid little things (S4)

what was it, I think summat happened in my family and that started me hanging about with the wrong people again and that started me using again. I'd just use it like little - if summat happens in my family or summat I'd use that as an excuse to use heroin again, do you know what I mean? (S2)

it's like when you've got, when your probation officer's on your back and the nurse is on your back as well, you know, and you come here and you feel a bit sort of like the whole world's against you because like this is your sort of world at the time, or life, and the probation officer and the nurses like you given them loads of grief, then er it can be a bit like everyone's against you, sort of thing (S1)

DTTO, it was going all right for a bit, then there were problems and I started missing it completely cos I had problems at home like Basically me and the missus was having arguments, yeah, the missus walked out like, you know, cos I stayed round at some girl's house for a couple of nights, she started getting all funny My missus, yeah, she done disappearing tricks, I thought fuck it, you know if I haven't got her I ain't going to bother sticking to it properly, know what I mean? Don't get me wrong, I still turned up, but then I started doing like crime, you know, I just gave up really To feed the habit. (S5)

At the time these clients resisted in various ways attempts by staff to get them to resume abstinence: there were short term gains in some cases but overall the drift was back towards daily use. In these later accounts however there is much less sense of inevitability: there are plenty of possibilities for the individual to identify key moments where choice could have been exercised. Given distance from the events, informants are more able to stand back and make a different kind of sense out of what happened. By and large there is a willingness to accept responsibility

rather than blame others. Where blaming was a factor at the time, there is now a willingness to see it for what it was.

It is likely that their DTTO involvement – in all but one case their most recent exposure to treatment – will have significantly contributed to this revision of thinking. It also confirms that unravelling previous sequences leading to drug use can be an important feature of relapse prevention work.

others getting away with it

[I used to say] I got to go to such and such Council office, you know, and I gotta go on a whatever, see you tomorrow, but what I think really is they should check it up a bit more, cos a lot of people blag em, do you know what I mean? They just take your word for it. [S5]

And um, some people they get too many chances as well. With me, I only had 2 chances I think and that was it, I was out. But then again I've known people who've had like six chances. It's like you've got one rule for one and a different rule for another. Should be all the same really. [S2]

Issues of responsibility and trust make frequent appearances in these accounts. The consensus among researchers (eg De Leon 1986) is that coercing attendance on treatment programmes can be a strong influence on retention in the early stages but that for long term positive change it needs to be replaced by elements of compliance and then co-operation. Striking the right balance for individual clients at different stages on the treatment pathway risks being perceived by others who are floundering as unfair.

The DTTO, it's not an unfair place, if you don't put the work in they can't help you [S4]

it was a bit of a blag but when I got there and started doing it, I thought yeah, it was actually okay, so like I didn't mind doing it until I started like using again [S5]

what stopped you from talking about it first

if I told my mum that I woke up and I wanna use, my mum would take it the wrong way. My mum would, she'd say, get out of my house [S4]

I knew I wasn't going to get another one [ie detox]. I know I wouldn't have been given another one, it'd already come up positive um they told me basically that you know, I'd had three already like, and they can't, I understand that they can't just keep on giving you detox after detox, ridiculous innit really but so in my wisdom I thought, you know, I didn't want to go back to Court obviously so er you know I started giving false urine samples [S1]

Sometimes I did, yeah, but there were other times I never, so in a way it is my fault because I never asked for it. But sometimes I'd say summat, I didn't like it cos I'd say summat to one counsellor, and like it's meant to be private and confidential and then say two days later another worker comes to me or another one says, I've read this, that, or the other one's happened, and I don't like it like that. If it's private and confidential it should be between you and like the keyworker. [S2]

You don't really want to use really, you just think you want to use. So deep down after, when I don't want to use and I use, after I feel terrible about it I've let myself down, yeah [S4]

what I could have done differently

Yeah, I could have done anything really, I'm like that, I like physical stuff, I could have went to the gym, I could have done anything. But to be honest, when I woke up it was just there in my head, and once summat gets in your head – I could have done anything really, there's so much I could have done that day now I think of it, I could have done anything. My rugby team, the estate rugby team, they play every Sunday morning, I could of just went down there, summat simple as that, and that would have took, after half an hour my mind would have been off it, would have been gone from it, but to be honest, deep down the stronger bit of me wanted to use and it just won at the end of it [S4]

If I'd have spoken to someone that I know, it could have happened, I'm not saying it would have happened, it might have happened, if I'd just had someone

to speak to on that morning and tell them that I want to use. Even if it's just a five minute chat, do you know what I mean, just a five minute chat for someone to say, Blimey, is that going to be a good idea? Or just summat, do you know what I mean? As simple as that to make me think twice about it. (S5)

I could have spoke to someone, you know what I mean, after missing the DTTO like, but I didn't, I was bottling it up like, basically. (S5)

Um, myself, if I was still around now, I don't think I would have fucked up, I would have stayed, well tried my best to stay clean, I'd have put more effort into it um cos at the end of it before I got kicked out I weren't really interested in the groups and that, when I was using I just sat there and like not saying anything. I think I'd put more effort into working on it now, I'd just try a bit harder, do you know what I mean (S2)

Considering that all of the informants were non-completers, and that there was marked variation in how much progress each was perceived to have made while on the order, there was a surprising level of consensus that resorting to drug use was but one of several options available to them at the time of their lapse. All informants had tools at their disposal from attendance on the programme that, had they chosen to deploy them, could have averted relapse.

giving up on the DTTO

I started getting back on the heroin and crack. I still turned up and that, just to show my face, but then it just got to the point where I was having positive urine samples all the time and they were saying look it's too much, and in the end I just stopped going, it didn't seem the right thing for me no more, and I thought the only thing that can help me now is prison. It just seemed like I was wasting my time and other people's time That was it really. Gave up on it (S4)

at the end of it before I got kicked out I weren't really interested in the groups and that, when I was using I just sat there and like not saying anything (S2)

it was a bit of a blag but when I got there and started doing it, I thought yeah, it was actually okay, so like I didn't mind doing it until I started like using again
(S5)

A return to daily class A use heralded, in each case, the beginning of disengagement with the order. Swift intervention seems to offer the best hope of getting someone back on track, but the nature of that intervention and how hard it is best applied is always going to depend on individual circumstances. That in turn risks antagonizing other clients who resent being treated differently.

With me, I only had two chances I think and that was it, I was out. But then again I've known people who've had like six chances. It's like you've got 1 rule for one and a different rule for another. Should be all the same really when I was using they said well, we'll give you a week to like sort yourself out, and where it got that bad a week was no good to me, wasn't no good. And about a week later they said well it's your final chance, if you're not clean then you're out. And a week later he told me I had to go. But then there's other people using, giving like I don't know how many positive urine tests and they're still there,

The rather black and white view expressed here is from an informant who dropped out relatively early and continues to use class As. It should be set against this more balanced view from an informant who lasted much longer on the programme and whose drug use since that time had been only sporadic.

I suppose here like you know earlier on, definitely earlier on, it was so easy to get a detox, I mean you could start using for a week, then you'd come and see the doctor on Tuesday like, be started on Subutex on the Thursday and it was so quick that I dunno, probably, you know, there is a lot of complacency with it, I used to get complacent with it because you know that to a certain extent you know that if you fall, if you trip up, like, you're going to get picked up.

I would have liked another detox but I didn't get one As it turns out, I sorted it out meself, you know, with the help of outside, but who knows, if I'd done that, you know, if they had helped me on the last occasion with that detox I might have stayed clean, I don't know. It's difficult, you know, you don't really know unless you've tried, sort of thing.

it's difficult, you know, where to draw the line, I think, definitely. You know like the staff side of it here, when do you stop giving people detoxes? (S1)

how it ended

I knew I wasn't going to get another one (ie detox). I know I wouldn't have been given another one, it'd already come up positive um they told me basically that you know, I'd had three already like, and they can't, I understand that they can't just keep on giving you detox after detox, ridiculous innit really but so in my wisdom I thought, you know, I didn't want to go back to Court obviously so er you know I started giving false urine samples. (S1)

it just got to the point where I was having positive urine samples all the time and they were saying look it's too much, and in the end I just stopped going, it didn't seem the right thing for me no more, and I thought the only thing that can help me now is prison. (S4)

X did offer me a bed in the hospital to do a detox like, but you know I refused for the simple reason that I don't like hospitals, you know. X says if you want to be off it, you go, but you can't make somebody go you know, I don't like hospitals full stop, so I won't even go. I thought I'd do it myself, I started taking um, what was it, the ones you put under your tongue (S5)

These accounts all describe a high level of flexibility on the part of medical staff. Informants recollected that they gave up on the DTTO, rather than that staff gave up on them. S4 described a different staff response

I started using again and I volunteered, I told W, like I told W that I was using, and like after that it's like I wasn't getting as much support as I was when I was using, when I wasn't using I mean. When I wasn't using W would be asking me questions all the time, they'd be asking me if I was all right, you know, and when I started using it was like no one would pay any attention to me, and I just thought phew, it should be the other way around

However, it is important to place this in context. S4 had been recommended for a DTTO only on the basis that he attend and complete a residential course of treatment. He decided to quit against the advice of all staff involved. The DTTO team could see no benefit in supporting a continuation of his treatment in the community once he had resumed class A drug use.

how I see it now

To be honest with you, then I didn't care, I just knew I had to go to prison to sort myself out, that's what it boiled down to. (S4)

At the time I was angry yeah, but now I know it's my own fault cos at the end of the day I did get a warning and really I just didn't pay any attention to it,..... Now I face it that it was my own fault. But then when I was on the DTTO I thought no it's not my fault, it's theirs, they should have given me another chance (S2)

It's different now. At the time I was angry yeah, but now I know it's my own fault cos at the end of the day I did get a warning and really I just didn't pay any attention to it, I was using heroin, I was on methadone still and no I didn't even need it, I had methadone to sort me out, but I was just getting a bit greedy. Now I face it that it was my own fault. But then when I was on the DTTO I thought no it's not my fault, it's theirs, they should have given me another chance (S2)

I think that's what's changed me, I think first. I think a lot, I used to just, straight away I wouldn't even think about nothing, I'd just do what I think I've got to do, go and do it. And now I know I haven't got to do that, I can do this, or this. That's what I think it is, now, for me, I've grown up a lot. That's what I think it is, I've just grown up a lot. (S4)

Inferences

Broadly speaking the data from these informants tend to support some of the views about factors influencing treatment retention expressed in the literature. The suggested three part schema of these factors – coercion, client characteristics and treatment characteristics – seems to match reasonably well the array of components in the DTTO experience that these informants are reporting. Examining these factors in their local context does point the way to some interesting questions about the service provided and the possibility of a better understanding of how DTTOs come to be curtailed mid term.

coercion

Informants owned to an ambivalence of feelings when it came to discarding their drug use, in accord with views commonly held among practitioners (eg Miller & Rolnick, 1991). While one informant felt that coerced attendance was unhelpful towards the end of his DTTO, others suggested that, at least for some time after the order was made, having to attend could help them to deal with wavering motivation.

In one case (S2), however, the coercive factor was inconsistently applied. While the client was clear that he had to complete stage one of his residential programme to comply with the directive of the sentencing court, he claims to have been unclear that this applied to stage two and he returned to Gloucester requesting admission to the community based programme after just ten weeks away. He resisted all attempts to return him to the residential setting. Over the next three months he gradually resumed heavy alcohol and drug use, and as the order gradually tailed away into a request on our part for revocation, a regular request on his part was to be transferred to another part of the country to reduce his exposure to drug using associates.

The National Treatment Outcome Study (NTORS) showed clearly that clients who remained in treatment for a critical period (> three months) tended to better outcomes than clients who left earlier (Gossop et al 2001). Even so, within sight of this key marker post, a client subject to the full sanctioning potential of the sentencing court was able to drop out of the selected programme.

It may be useful for the team to consider, therefore, whether there is room to build more consistency and clarity into the assessment, proposal, sentencing and review process. This may especially benefit clients who move from one treatment provider to another, or

from one stage of treatment to another. The better informed the client is about his or her responsibilities in regard to the order, not just at the time of sentence but further down the line, the less room there will be for grey areas to develop where staff and client spend their time contending rather than working together for common cause.

Young & Belenko (1999) advise us that the element of coercion, one of the most powerful interventions in the DTTO programme arsenal, is most effectively deployed only when the protocols of enforcement have been clearly spelled out. This is in line with findings of the Sheffield study, that consistency across the different elements of DTTOs, including the courts, seemed to help participants overcome some of their own disorganisation (Ricketts et al, 2002)..

Models of Care, part 2 (2003) develops this point specifically in relation to DTTOs, suggesting that the assessment process should include

a signed statement from the offender that the requirements of the order and the consequences of as failure to comply have been fully explained by the responsible officer and confirming that the offender is willing to comply with the order (p 186).

This is of course an application of the principles behind Integrated Care Pathways (p 26, MoC 2). The literature of counselling, too, regularly emphasizes the importance of clear, mutually negotiated and agreed initial contracting (eg BACP Code of Practice 2002)

the therapeutic alliance

It is interesting to examine how applying coercive elements might fit into the context of therapeutic relationships with members of staff.

A developmental model of clients' engagement with DTTOs derived from the Sheffield study (Ricketts 2002) shows relationships with staff featuring prominently in the middle stage and less so in the stages either side. The level of therapeutic alliance between staff and client has been identified as a key retention in treatment indicator (De Leon 2001; Joe et al 2001; Saarnio 2002) and this is in line with many earlier studies that put the client-therapist relationship at the heart of the helping process (eg Highlen & Hill 1984; Goleman 1985; Egan 1990).

Tracey (1984) examines “stages of influence” that unfold as counselling relationships develop and argues that, to be effective, challenges to client behaviour, attitudes and beliefs need to occur in the middle stage, that is after an initial period of trust and rapport building. To a greater or lesser extent, the informants who reported head-on collisions had weathered this early stage, and their falling out in the middle stage suggests the possibility that either the challenge was too fierce or the relationships still too flimsy for conflict to be endured at that point.

When a client begins to struggle with expectations that he or she describe as beyond their capabilities, it might be useful to consider what process has generated those expectations. If they are enshrined in the care plan, signed up to by the client and endorsed by the sentencing court, then in the interests of programme consistency and integrity there is a strong case for those expectations to be preserved. Even so, there may be implications for the assessment process: how closely did our appraisal of the client’s needs, resources and goals match the client’s?

It may be, on the other hand, that the client has not signed up to further objectives developed by practitioners as the order has been unfolding. Maluccio’s (1979) study of clients terminating counselling found that clients were frequently much more pleased with outcomes than their counsellors, who tended to be more ambitious about changes and goals to be achieved.

These possibilities support the case for regular review of both client and staff goals and expectations with an eye to both parties retaining a strong sense of shared objectives. Dryden (1988) argues persuasively for reflective opportunities to be timetabled into therapeutic relationships so that goals and tasks can be systematically reviewed, updated and ideally shared.

drug use

All informants report a return to class A drug use, ie heroin and crack, as a major factor influencing their disengagement with the DTTO programme. Generally speaking, clients located their lapses in the domain of personal choice and responsibility, but given the battle all of these informants were having with their drug use, the question is nevertheless raised as to whether there was room for more flexible approaches to

prescribing. After all, a major criticism of the Gloucester pilot project was its initial insistence on very rapid progression (“too far too fast”) to drug-free status, when the research evidence was that three months was the minimum period required simply to engage with this client group (Turnbull et al 2000).

Recent researchers have tended to the view that higher prescribing levels, of methadone (Farre et al 2002) and of buprenorphine (Ahmadi, 2002), are accompanied by significantly less drop out than lesser prescribing levels.

Similarly, the broad brush findings of the Audit Commission (2002) highlight “inflexible approaches to dosage policy and methadone maintenance programmes” as a significant influence in treatment drop out. Accompanying the imperative that drug-misusing offenders “should be retained in treatment for at least three months”, Models of Care part 2 insists that the option of methadone maintenance should be available to criminal justice clients, although this is not necessarily specific to DTTO clients.

However, raising these questions risks, at least to begin with, generating more heat than light in the debate about how best to serve our client group. One issue is around the amount of credence medical practitioners attach to the accounts of their patients: anecdotal evidence suggests that clients may inflate accounts of drug use if they perceive medical staff as sceptical about reported levels of drug use. Another concerns the possibility that maintenance prescribing for some clients might erode the ability of others to commit themselves to abstinence – some of these informants identify fairness as an important treatment ingredient and contact with other users as a distinctly negative influence.

Nonetheless, it may be worth considering if there is more latitude for maintenance prescribing in individual cases, without sacrificing programme integrity. The purpose of the DTTO, after all, is simply

to bring persistent and dependent drug-misusing offenders into a closely supervised programme of treatment in order to effectively break the links between their drug misuse and their offending.

(p 186, MoC part 2, 2003)

Conclusion

Considering that this study is occupied with non completing clients whom one might expect to be the programme's fiercest critics, their accounts constitute a surprisingly benign view of their DTTO experiences. Since their orders were revoked, two informants had made headway towards their professed goals at the time of the original sentence, while the two other had made some progress in changing attitudes and perhaps strategies though this was not at the time reflected in their circumstances. Collectively, the four accounts suggest areas for team discussion that could generate ideas about how to stay engaged with clients who start well and then lose direction in the mid stage. These might include:

- What possibilities are there to beef up the initial contract between offender, DTTO team, and sentencing court, in order to gain more leverage in the event a client starts to lose their way?
- What opportunities are there to build on and further strengthen individual staff-client relationships?
- When a client begins to struggle in the mid-phase and matters of enforcement become more pressing, what opportunities might there be to balance this by boosting levels of support?
- How much room is there to meet the prescribing preferences of struggling individuals more closely and nonetheless remain within (a) clinical guidelines and (b) overall treatment strategy?

Epilogue

With some of the views of the service users safely represented, I will add one aspect of the research process itself that may help understand why drug treatment is sometimes difficult in criminal justice settings..

Although I have worked with this team for over four years and am familiar with the current system of client files and records, finding what I wanted was still a challenge, Much time goes into keeping files up to date, especially on the part of Probation colleagues who regularly find the task eating into their time with clients or even their time away from work. On the part of administration colleagues, too, much time went into tracking down and laying hold of the files needed in this study.

It still surprises me, opening these large files, how difficult it is to find treatment relevant information despite the assiduous contributions of team members. The present system of collecting contact sheets and court papers seems to have evolved to meet the agenda of sentence management and enforcement. As an aid to drug treatment provision, it is a limited tool. Valuable information, instead of leaping off the page, jostles for attention with numerous court protocols.

In a multi-skilled team, practitioners without probation training struggle to find their way round these files. What they may do as a result is adopt a minimalist approach to the contact sheet, simply recording attendance, and save more detailed, nuanced accounts for their own records to which other members of the team may not have access. Thus the file tends to remain in the domain of probation, rather than representing a shared understanding to which all members of the team contribute.

In this way an important opportunity for team reflection on individual clients' progress becomes lost. Looking back on what the records had to say about these informants I was struck by patterns that emerged as the DTTO progressed, or, even more interestingly, patterns from previous treatment or probation involvement that re-emerged. Teasing out these patterns was time consuming, probably more so in the hurly-burly of the building where treatment takes place. What would be more helpful is a system of record keeping that is (a) user friendly and (b) clarifies rather than conceals key issues about how a client's treatment is progressing.

In my opinion, devising such improvements should be preceded by a period of consultation with those who will be most affected, in line with good practice in organisational change as outlined by, for example, the NHS (2002).

This matter of the files illustrates a key difficulty faced by teams tasked with providing drug treatment in a non treatment setting. At the setting up stage there is much to think about and it is tempting to borrow existing systems hoping they will serve a different purpose from that for which they were originally designed. All too often these systems, imported from other domains, generate new tasks that devour staff time and energy but, on analysis, prove to be of limited relevance to the primary task – in this case treatment. Rethinking the design of some of these systems could further enhance the DTTO team's ability to deliver.

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